HEALTH CARE CRISIS: PROBLEMS OF COST AND ACCESS FOR CHILDREN OF COLOR

HEARING

BEFORE THE

TASK FORCE ON HUMAN RESOURCES

OF THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

NOVEMBER 19, 1990

Printed for the use of the Committee on the Budget

Serial No. 5–14

U.S. GOVERNMENT PRINTING OFFICE

35–971 ⇆ WASHINGTON : 1991

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

COMMITTEE ON THE BUDGET

LEON E. PANETTA, California, *Chairman*

RICHARD A. GEPHARDT, Missouri
MARTY RUSSO, Illinois
ED JENKINS, Georgia
MARVIN LEATH, Texas
CHARLES E. SCHUMER, New York
BARBARA BOXER, California
JIM SLATTERY, Kansas
JAMES L. OBERSTAR, Minnesota
FRANK J. GUARINI, New Jersey
RICHARD J. DURBIN, Illinois
MIKE ESPY, Mississippi
DALE E. KILDEE, Michigan
ANTHONY C. BEILENSON, California
JERRY HUCKABY, Louisiana
MARTIN SABO, Minnesota
BERNARD J. DWYER, New Jersey
HOWARD L. BERMAN, California
ROBERT E. WISE, JR., West Virginia
JOHN BRYANT, Texas
JOHN M. SPRATT, JR., South Carolina

BILL FRENZEL, Minnesota
Ranking Republican Member
WILLIS D. GRADISON, JR., Ohio
WILLIAM F. GOODLING, Pennsylvania
DENNY SMITH, Oregon
WILLIAM M. THOMAS, California
HAROLD ROGERS, Kentucky
RICHARD E. ARMEY, Texas
JACK BUECHNER, Missouri
AMO HOUGHTON, New York
JIM McCRERY, Louisiana
JOHN R. KASICH, Ohio
DEAN A. GALLO, New Jersey
BILL SCHUETTE, Michigan
HELEN DELICH BENTLEY, Maryland

TASK FORCE ON HUMAN RESOURCES

BARBARA BOXER, *Chair*

*LEON E. PANETTA, California
*RICHARD A. GEPHARDT, Missouri
RICHARD J. DURBIN, Illinois
MIKE ESPY, Mississippi
DALE E. KILDEE, Michigan
MARTIN SABO, Minnesota
ROBERT E. WISE, JR., West Virginia

*BILL FRENZEL, Minnesota
*WILLIS D. GRADISON, JR., Ohio
WILLIAM F. GOODLING, Pennsylvania
JACK BUECHNER, Missouri
JOHN R. KASICH, Ohio
HELEN DELICH BENTLEY, Maryland

LYNNE RICHARDSON, *Associate Staff and Task Force Director*

---

*Ex Officio.

Public Laws: 101st Congress / 2nd Session / House Hearings / 1990 / File 2

CONTENTS

HEALTH CARE CRISIS: PROBLEMS OF COST AND ACCESS FOR CHILDREN OF COLOR

MONDAY, NOVEMBER 19, 1990

HOUSE OF REPRESENTATIVES,
TASK FORCE ON HUMAN RESOURCES,
COMMITTEE ON THE BUDGET,
Los Angeles, CA.

The Task Force met, pursuant to notice, at 9:10 a.m., Mark Taper Hall of Economics and Finance, California Museum of Science and Industry, Hon. Barbara Boxer, Chair, presiding.

Mrs. BOXER. Good morning, everybody.

Although some of our witnesses are having a hard time finding this wonderful spot—and it is a wonderful spot—we are going to begin, for a couple of reasons. We have got to get through a very important discussion today and get it all on the record, and my dear friend and colleague, Congressman Dymally, who has been such a fighter in this community for health care and for the people he represents and the people of America in this field, has to leave us very soon. He came here as a special favor to me. He is not on this Task Force on Human Resources. He came here especially so we could make it an official meeting of the Task Force.

For those reasons, I am going to give a very brief opening statement, and then I am going to ask him to do the same, and then we will begin with our first panel.

This is the field hearing of the House Budget Committee, Task Force on Human Resources. The Task Force is charged with the responsibility of recommending funding levels for education and health programs to the full Budget Committee.

During the 2 years of my chairmanship, the Task Force has highlighted some of our most critical health care needs. Over the last year, this Task Force has held hearings on AIDS, Medicare, biomedical research, veterans health care, and the Women, Infants and Children's Program.

The people best able to advise us on health care issues are the people fighting the battles at the frontlines, some of you who are here today. And that is why we are here today, to find out how people in our California communities are coping, to identify key problems, and perhaps some innovative responses, and we can take those back to Washington with us.

We are aware of some shocking statistics—as many as 37 million Americans have no health insurance coverage whatsoever. Medicaid serves only half of our poor children—while 20 percent of our children are below the poverty line. The United States ranks

behind 19 other industrialized nations in our infant mortality rate—we have 40,000 infant deaths per year. Over 70,000 babies are born every year to women who have had no prenatal care. And I want to point out that my budget staff today has informed me that the new statistics on the Los Angeles infant mortality rate are out today, and it is not good news. The infant mortality rate is rising, and we must do something about this.

These children are our future. If we are going to compete in a global economy, we can only do it with an educated work force and a healthy work force, and these are the kids who are going to be in that work force.

These figures are all the more disturbing in light of the tremendous resources we do devote to health care. I have long advocated an approach to health programs based on the cost-effectiveness of early intervention/prevention. We have to reach out to people before they are ill or pregnant or hooked on drugs.

We are bringing together today local elected officials, health care providers, and community advocates, to dramatize health care issues. Many of these issues were debated very visibly in recent weeks when we fought over the budget priorities, and now we will go back to Washington facing yet another budget, and the information we will learn in these hearings, particularly about the status of our children, our most precious and valuable resource, will help Congressman Dymally, will help me, as we fight for the kind of priorities we need in this great Nation of ours.

I will be glad to turn it over now to my dear colleague, Mr. Dymally.

STATEMENT OF HON. MERVYN M. DYMALLY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. DYMALLY. Thank you very much, Chair Boxer. I am indeed very pleased to join you to review this very important subject.

If I may digress just a moment and be a little sentimental about this facility, I used to represent this area, and when I declared my intention to run for the Assembly, two of my dear friends, Congressman Hawkins and Congressman George Braunwell, members of the Assembly then, held hearings here, and that was my debut in testifying before subcommittees.

In addition to that, I notice a great deal of my friends here from the King Hospital, from the county, and I am especially sentimental about Sylvia Drew Ivie because the Drew School is an institution which I particularly had a keen interest in as a member of the California Senate. In fact, I authored the legislation which brought Drew and UCLA together.

I have a long interest in health care matters, even though you do not see any evidence of it in Congress, the committee being what it is, and I note with interest that Dr. Bean is here from the King Hospital.

I am very pleased to join in what is a very, very critical issue across America and especially in Los Angeles County. At some point, you will learn about the trauma situation which we have here. Most of the private hospitals are closing their trauma centers. This impacts on the public hospitals, especially Martin Luther

King Hospital, and we are very, very concerned about the role of the United States in child health care.

In some instances, we have a higher mortality rate than two of the countries which we support, and this all approach of preventive medicine is one which will take me away from here today because I have a doctor's appointment. I am a member of an HMO. When you get into an HMO system, you cannot change your appointments as you do with private doctors.

So I had it canceled several times during the extended session, and I must leave you, but I want to congratulate you for coming here today and touching on a very, very sensitive and very critical issue, and we hope that your deliberations here today will influence the Budget Committee to focus attention on preventive medicine among young children in America.

Thank you very much for this opportunity to be with you today.

Mrs. BOXER. Thank you, Congressman, so very much. Good luck with your appointment, and I want you to go right now so you make it. I know what you mean about canceling appointments because I had lined up the dentist, the doctor and everything and kept cancelling as we kept staying longer and longer in Washington.

Mr. DYMALLY. Yes.

Mrs. BOXER. And we have to practice what we preach to our constituents about prevention. Thank you very, very much.

Mr. DYMALLY. Thank you.

Mrs. BOXER. And I will be in touch with you. I will send you, by the way, the hearing transcript so you can look it over.

Mr. DYMALLY. Very good.

Mrs. BOXER. I will be happy to call our first panel. We still think some members are looking for this place. Whoever is here of the first panel, please come forward.

Bob Gates, and Dr. Bean and, I want to say it right, Mr. Cousineau. I have taken French. So, I should be able to do that easily.

Mr. Gates, Director of Health Services, the County of Los Angeles, we are so glad you could come out to share your views with us. I hope that you will summarize, if you have written testimony. If not, we will take it down into the record.

I want all the witnesses to know that the Members of this Task Force will receive copies of the transcript of these hearings and some portions I will place in the Congressional Record if I feel they are particularly meaningful to our subject at hand, which is really the problems of cost and access for children of color to health care systems. So, why do you not proceed?

STATEMENT OF ROBERT C. GATES, DIRECTOR OF HEALTH SERVICES, COUNTY OF LOS ANGELES

Mr. GATES. Thank you. I do have written testimony. I think my staff has provided it. I will sort of summarize and expand upon that and not, certainly not read it.

We do have a large system of health care here in Los Angeles County. We have six different acute care hospitals. We operate, including the King Hospital as mentioned, and L.A. County USC Medical Center, Harbor UCLA Medical Center, Rancho Los Amigos

Hospital, Olive View Medical Center and High Desert Hospital, a combined capacity of about 3,000 beds or 3,000 patients per day in those hospitals.

Mrs. BOXER. In-patients?

Mr. GATES. In-patients.

We have five very large out-patient operations, called Comprehensive Health Centers, and we have 42 smaller neighborhood health centers that are the more traditional public health care facilities.

The total budget is just under $2 billion, and we have about 25,000 employees, which is obviously an extremely large operation.

We provide over a million in-patients days per year. Something like 3 million out-patient visits take place per year in our system.

Despite that volume, we still have lots of problems providing adequate patient care in our system. I think the obstetrics problem provides a particularly good example of that situation.

We have been essentially inundated with new babies in our system. Four of our hospitals provide obstetrical and delivery care, and the total capacity, rated capacity, of those four hospitals is 34,900 patients per year or births per year.

Last year, we had about 43,000 deliveries in those four hospitals, which is about 23 percent above our capacity. Beyond that, we contracted out the delivery of another almost, I guess, 8,700 infants in the private sector. So, our system alone is responsible for over 50,000 deliveries, and we are seeing an increase not only in the total number of births in our county but also in the county's proportion of it. We are responsible for an increasingly large number of those infants.

Mrs. BOXER. What percentage of the infants born in Los Angeles would you say—did you say you delivered 50,000?

Mr. GATES. 50,000.

Mrs. BOXER. How many births are there in the county?

Mr. GATES. Just under 200,000. So, we are in the range of 26 to 27 percent, and that number years ago was around 20 percent. It is gradually over time increasing, and we have been inundated with problems, and we sort of have no choice but to deal with it.

The underlying problem, I might say, is primarily the State's MediCal Program. Under, I guess it was, OBRA, the Omnibus Budget Reconciliation Act, of a couple of years ago, all infants were eligible under our State MediCal Program for care. So, essentially, all of these are signed into the MediCal Program, and it is not really that they do not have a source of payment, it is that the private sector has not found them desirable patients to bring into the private sector.

Part of that has been the low MediCal rates. The State rates for MediCal have not been attractive to hospitals, and they have particularly not been attractive to physicians. So that while they come with money, we have ended up in the role of essentially placing these patients in the private sector through special contracts, and we have had to augment the MediCal Programs, is what it boils down to.

We have created our own medical group where a physician bills us, we pay them very quickly to get around the payment lag. We then turn around and bill the State, and we may wait 6 months

before we receive payment from the State, but the physician only waits 30 days for payment from the county.

We also provided malpractice coverage for physicians.

Mrs. BOXER. This is very interesting to me because this is, by the way, about my seventh or eighth hearing and this problem of MediCal comes up every single time, and what I am hearing you say is you have seemingly an innovative idea here where you try to get the physicians taken care of so that they do not turn away these patients.

Do you pay them the same scale that MediCal proposes or do you boost the payment?

Mr. GATES. We primarily pay the MediCal payment.

Mrs. BOXER. So that, in other words, where the doctor says there are two problems with MediCal; (1) low reimbursement, (2) having to wait forever, you try to at least resolve the one, having to wait forever?

Mr. GATES. Yes, and I think the obstetrical fees are better than some of the others. To have a whole team together, you need not only the obstetrician, you need the anesthesiologist and the pediatrician, and we have supplemented the amounts of payments for anesthesiologists and pediatricians.

The State has recognized the need to increase the fees for obstetricians, probably not really adequately, but——

Mrs. BOXER. What is the rate for a group now? What does MediCal pay for——

Mr. GATES. I cannot quote the exact amount. It is a single amount that covers both Caesareans and—less than a thousand dollars.

Mrs. BOXER. A thousand dollars?

Mr. GATES. It is not too bad.

Mrs. BOXER. Compared to some of the reimbursements?

Mr. GATES. Compared with other reimbursements, and it is better than, as I say, pediatricians and anesthesiologists.

Mrs. BOXER. Right.

Mr. GATES. But we are making some headway by ourselves acting as a billing intermediary.

Mrs. BOXER. Interesting. Does anybody else do that as far as you know?

Mr. GATES. Not that I know of, no.

Mrs. BOXER. And this is the county that is stepped in to do this. It is very interesting.

Mr. GATES. Yes, and, again, it is to relieve the load on our hospital. Despite everything we have done, and we have increased the number of births and we have been able to place out in the private sector, and I could describe some other things, we have done a lot of things, and despite everything we have been able to accomplish, we are still seeing more births this year in our own four hospitals than in the private sector.

We have contracts with individual hospitals, and we provide them a degree of malpractice coverage, also. We have been able—we have this MediCal contract program, I am sure you have heard about it, here in the State. We have been able to work out with the State that there is a special rate that is provided to noncontract hospitals that is different than our normal rate that we would get

and pass on to them, and I think the State has recognized somewhat the problems, but, as I say, despite everything, we have not been able to solve the problem completely.

Part of it is still structure within the MediCal Program. They do not pay any additional amount for particularly sick or critical babies. They pay a flat amount per baby, and, therefore, the private hospitals mostly want just the low-risk kinds of births.

Mrs. BOXER. Right.

Mr. GATES. And that makes our situation even worse because not only do we have an overload, but it tends to be an overload of the more critically ill babies that are much more difficult to care for, the high risk kinds of problems.

We also have a substantial number of substance exposed infants in our own system. King-Drew Medical Center is a particular example of that. Dr. Bean, I am sure, will be talking more about that particular problem.

We have done a lot in the way of prenatal care to try and solve as many problems as we can initially. Each year, we have added another million or two into our budget despite all kinds of other budget problems. We have made prenatal care a priority, and we are just barely keeping up with the increase in volume there.

Mrs. BOXER. What is your reach-out to reach the pregnant woman to get her to come in for prenatal care?

Mr. GATES. We have done some things. We have worked with some private organizations to try and get word out. We have gotten a grant and there are others, including Dr. Bean, who can talk a little bit about some of the related things we have done to try and reach minorities.

The main thing we have done is simply keep our waits low. We set a target that no new mother coming into our system would have to wait more than 2 weeks for an initial visit, and with that, we have been just barely able to keep up with the demand. To a certain extent, we have not wanted to heavily advertise and have major efforts because we are just struggling to keep up with the volume that we have right now.

But, ultimately, we need more money in this area, and we really need to reach out particularly in the black community. There are some things that we are doing to try to do something about the particularly high infant mortality rate among black babies, such as, "Great Beginnings for Black Babies."

Mrs. BOXER. So, what I am hearing you say, and I have heard this again all through the State, is that you cannot do too much outreach because you will not be able to give these people who come in any kind of quality care.

Mr. GATES. Yes.

Mrs. BOXER. So, you are doing the max you can possibly do with the resources.

How many, in terms of percentages, do you have any sense of who you are not reaching? Do you know the percentage of pregnant mothers you are not reaching?

Mr. GATES. Yes, that would be reflected, I imagine, in the number of mothers who still come into our system with no prenatal care.

Mrs. BOXER. And how many is that percentage?

Mr. GATES. I, unfortunately, cannot give you that figure. I think it is—I should not guess.

Mrs. BOXER. Do not guess.

Mr. GATES. I could provide you that information——

Mrs. BOXER. I would really appreciate that.

Mr. GATES. It is about 5 percent. And I guess I could go through other areas. I think, in my mind, that kind of dramatizes the situation we are in.

The county itself has extremely limited funds. We have relied very heavily on the State as our main source of funding. The State has been very parsimonious with available funding, and I guess you have heard that. Your opening statement reflects a lot of the kinds of things I might have said, but the State is sort of where we get most of our funding, and there has not been much in recent years.

I think we believe at this point we need either added State or Federal funding or some way of getting out in the community and improving care to children maybe in a focused way, and we need not only them to have coverage but also them to have fees and other parts of the program itself, such that the private sector really is interested in providing care.

We clearly cannot do it all, and when there are failures, we are the ones who end up with overcrowding and undesirable situations on our own. So, obviously we would prefer not to see that.

I think maybe I will just stop at that point. I could respond to further questions.

Mrs. BOXER. Thank you. Thank you very much. Mr. Cousineau.

STATEMENT OF MICHAEL COUSINEAU, EXECUTIVE DIRECTOR, HOMELESS HEALTH CARE

Mr. COUSINEAU. Thank you. Good morning. There are hundreds of thousands of people in Los Angeles County who are homeless, and I am testifying about those folks today because I believe very strongly that homelessness is in large part a reflection of both the crisis in health care that we are facing in Los Angeles and the crisis in affordable housing. They kind of come together around this issue.

We have very few resources to provide health care to this population, and most of that comes from the Federal Stewart-McKinney Act, and supplemented with private sources here in Los Angeles and foundations and other private sector funds.

In addition to that, I do want to mention that in spite of that, the vast majority of the health care that is provided to homeless people in Los Angeles is provided by the county. So, we are extremely interested and monitoring very closely the progress of the county health system, both at the hospital and at the out-patient sites.

The active barriers that are faced by homeless people, including homeless children, are very substantial. Just to give you a case of an individual that we are working on right now, which is an illustration of problems that are faced by the homeless, there is a young man who is a diabetic and recovering substance abuser, who every month goes to the county health facility to obtain his—see his physician which changes every month and to obtain his pre-

scription for insulin, and he tells us that every month, he waits between 10 and 12 hours for the appointment, and another 3 and 4 hours for his prescription.

One month, last month, he was so seriously ill and with other problems that he was not able to actually stay in the hospital and went back to his hotel and ended up in a diabetic coma and ended up in the emergency room that was closed. They took him to three different emergency rooms ending up at Kaiser West Los Angeles where he spent 2 or 3 nights in the emergency room because they would not admit him, and I sense somehow the county would have to pay for that.

The point is that these asset barriers that have been created by the volume in the last funding and support for primary health care for the homeless and emergency care really has provided some very difficult situations for our clients and patients that are homeless.

Eighty percent of homeless people in Los Angeles do not have health insurance, and this in part reflects the fact that many, in particular the single adults, homeless men and the people who are mentally ill, were covered under the old Medically Indigent Adult Program because they stayed on the supported program that ended, I believe, in 1982 or 1983, and all the responsibility for their care transferred to the county.

The county only receives about 60 to 70 percent of the actual projected costs of caring for those patients, and that percentage declined.

In addition, among the homeless are about 16,000 different families, and to do the math, figure every family has a couple of two to three children, there are about 30 to 40,000 children in Los Angeles County who experience homelessness at least once a year.

Within a few blocks of where we sit today are a 100 to 200 to 300,000 families who are doubled and tripled and quadrupled in very insubstantial housing for their needs. We have visited many of these apartment buildings and hotels and they are quite tragic, where people are living in conditions in which people are living.

There are hundreds of families that are living in hotels in the downtown area, and a large number of homeless families that have been studied both here and other parts of the country have shown that large numbers of these kids suffer from developmental problems. Many are victims of child abuse, neglect and many have both acute and chronic illnesses that have not been dealt with, that these studies from the Robert Wood Johnson Project show that at the rate of acute and chronic illness in our homeless children is two to four times as great as children who are similar but otherwise healthy.

The lack of facilities specifically for our very high-risk children and adults is something that the adult care for the homeless providers see every day. The problems of being able to provide adequate follow-up for children who are CHDP or early childhood intervention, and you identify a problem in a child through a CHDP program and then you have no place to send them that you can actually be assured that they are going to be provided with the care that they need.

The OB system that Mr. Gates has mentioned is something that there has been some improvements in the ability to provide prena-

tal care, but what has happened is that as a result of that, many of the county facilities have added or plan to add OB staff at the cost of providing care to the rest of the population, and, so, it makes it more difficult for people who need primary care or pediatric care to receive the care they need because now the county is so overloaded with providing obstetrical services.

This is something that many of the clinics have mentioned to me, and I wanted to mention today at this hearing, that somebody else may bring that up later on today.

The other thing that I think should be mentioned with respect to, because it is health care and does affect children, is the problem of substance abuse and mental health. It does overlap. Many of the people that are seen for primary care needs also have problems with the substance abuse and are mentally ill or homeless, and right now, the wait to get into residential drug treatment programs in Los Angeles is anywhere from 8 to 10 weeks. In some places, it is even longer, particularly for pregnant women, and there are only 10 programs in the entire county that take women or children.

In sum, I think the barometer for looking at the severe problem of access to health care in Los Angeles really are the problems of the homeless, and we can look at the subpopulations of the homeless, including children, the mentally ill, single adults, as a way to look at where ways and solutions can be identified for the bigger problem.

But, clearly, as Mr. Gates said, we need more resources. The problem of the uninsured has to be dealt with. Groups are beginning to work on that, but we also have to look at capacity and increasing the capacity of private and public clinics and health centers in Los Angeles to provide prenatal care.

Mrs. BOXER. Thank you.

I want to go back to something you said. You said before 1980, there was a State program that insured people who did not have insurance, the ability to go into a health facility, get treatment and the county would bill the State, is that correct?

Mr. COUSINEAU. Well, not just the county, they were—they had a MediCal card like anyone else.

Mrs. BOXER. Right.

Mr. COUSINEAU. But—so they could go to a private hospital or private physician or the county. The county was seen probably by half of those folks anyway, but what happened was that in 1982, those people were not linked to any kind of entitlement program, like AFDC or SSI. It was only paid for by the State and Federal Government did not provide any of the resources.

So, the State of California eliminated that program. All those people were eliminated from the MediCal rolls, and their responsibility was placed on the counties for providing their care with only a fraction of the amount that was needed to pay for this care.

Mrs. BOXER. So, now, the burden in this State and States all over this Union for people who are completely indigent, homeless, on MediCal, may not qualify, they may not fill out the forms, and if you have ever seen the MediCal form, of course you have, it was made an exhibit at one of my hearings, I would doubt that anyone in this room could fill out that form.

Mr. COUSINEAU. Right.

Mrs. BOXER. Perfectly.

Mr. COUSINEAU. And if you are mentally ill and you are on the streets, it is even more difficult.

Mrs. BOXER. Elderly, the mentally ill. An average person would have a very difficult time filling out that form.

So, what you are saying is there is this group of people in our country who would walk into a county facility and what you are saying is the county is not getting reimbursed adequately to care for these people?

Mr. COUSINEAU. In California, they are not. They have never received even the percentage of what MediCal was paying in 1982, when they were covering these people under MediCal, and even that is, I think, 30 to 35 percent of what the average cost of providing health care to these people are. So, they are given a fraction of even that.

Mrs. BOXER. So, I want to ask Mr. Gates this question. What is emerging to me as we go through these hearings is that there is essentially, I would say, four levels of health care as I have come to know it in this State, and that would be the insured patients who have insurance and can go to any doctor of your choice and get coverage. Then there are the insured patients who belong to an HMO and take advantage of that situation with its problems, and then there is the MediCal patient who is insured, and then, as I understand it, there is a fourth category which is the medically indigent.

So, when this first was brought to my attention, I said, well, I thought the medically indigent were MediCal patients. No, MediCal patients are a big step above the medically indigent who have nothing at all.

Now, if a medically indigent person walked into a county facility, do you get any kind of reimbursement whatsoever, Mr. Gates?

Mr. GATES. Not incrementally. These are people generally who are aged 21 to 64, as Mr. Cousineau said. They do not fit any Federal category.

In 1982, when the county took on responsibility, the State was spending about $700 million a year on this group, and we were given initially about 70 percent of that amount, which arguably was not such a bad situation at that time.

Mrs. BOXER. What was it called, the funding?

Mr. GATES. It was called the Medically Indigent Adult Program when it was a part of MediCal.

Mrs. BOXER. All right.

Mr. GATES [continuing]. And it has retained essentially that same name, Medically Indigent—I think technically it is called the Medically Indigent Services Program, MISP, at this time.

Mrs. BOXER. Does it include children?

Mr. GATES. Mostly not. Mostly children are federally eligible for MediCal.

Mrs. BOXER. All right.

Mr. GATES. So, we have below age 21, you do categorically fit for MediCal. If you are over 65, blind, disabled, and so on, but if you are none of those, then you would be eligible for this particular program.

We get a fixed amount of money each year, and we started out at about $200 million and now that has been eroded away, so that what in 1982 was a marginally acceptable figure is now down to, you know, 40 percent or less. Where we were getting about $200 million, it is now, I think, $90 million.[1]

Mrs. BOXER. You got $200 million to $90 million to cover people from the ages of 21 to 64 roughly who have no coverage, who fall between the cracks?

Mr. GATES. Yes.

Mrs. BOXER. And you are getting far fewer dollars. You are getting a quarter of what you got before, and I assume the burden has gone up.

Mr. GATES. Yes, it has——

Mrs. BOXER. Given the homeless population.

Mr. GATES [continuing]. Moved up, and there are some other factors. I guess in fairness I should mention that there were immigration reform funds that became available to somewhat help fund this group and a cigarette tax was passed which supposedly was going to be new service, new funding, and I think in reality it has become a substitute for this other funding.

So the money has not declined quite as dramatically, but I think funds that were intended for other purposes have in fact been substituted, and improvements that should have been made have not been capable of being made.

Mrs. BOXER. Since our hearing is focusing on children, I wanted to raise the issue that, Mr. Gates, you have some very good testimony in terms of setting the stage for what we are looking at here, which is a very bad picture for kids in the State, very terrible picture for kids in this State.

When you say the percentage of 2-year-olds who are not fully immunized went up last year from 47.9 percent to 52.3 percent, is that in this State or in this country? That is on page 6 of your testimony.

Mr. GATES. Yes.

Mrs. BOXER. You say, "In the recent measles epidemic, children of color account for half of both the cases and the deaths of those under 5 years old. Age-appropriate immunization could have prevented most of these cases."

Mr. GATES. That is true.

Mrs. BOXER. Are you talking California here in this particular incident?

Mr. GATES. I think I am talking within the State.

Mrs. BOXER. All right.

Mr. GATES. Let me see.

Mrs. BOXER. I would ask you to double check that.

Mr. GATES. Excuse me. County. Yes, my staff is saying this is within the county.

Mrs. BOXER. So, what you are saying to me today is that in this county, more than half the kids are not immunized?

Mr. GATES. Yes.

Mrs. BOXER. And that is shocking, completely shocking.

---

[1] The correct figure should be $83.5 million.

Mr. GATES. These are the ones under age——

Mrs. BOXER. Two.

Mr. GATES. Two.

Mrs. BOXER. The ones that are most difficult to reach because once they are in school——

Mr. GATES. And most liable for things like measles.

Mrs. BOXER. I wanted to talk about that for a minute because I am trying to put together some legislation that would guarantee children their immunization shots. That would be a Federal program.

I think you point out so clearly in your written testimony that this is a money sinker, and when I was in San Diego, I learned about one particular case where a little child contracted measles and the county did everything it could to save the life of the child and expended $800,000 trying to save the baby, did not, lost the baby. Now, we have spent $800,000 trying to save the baby. How many immunization shots at $16 per shot could we have bought?

So, it a complete outrage that we are seeing these kinds of numbers, and this is something that we just should not stand for, and I would say with any other population, there would be pickets outside the capitol and outside the White House, but this is the most vulnerable underrepresented population.

So, I want to be a voice in the Congress for this population. So, what I am going to do is put together a resolution that would be sent to the Congress, a resolution that the Administration develop a guaranteed immunization for all of our children that, when they are born, they have essentially a book of coupons, as you would have when you buy a new car, and when you buy a new car, you know, 1,000 miles you get this check up, and at 2,000 miles, you get this check up, that this guarantee would go with the new baby in America, that this country is saying we believe in you enough to immunize you at a minimum, and that is what I am trying to develop, and I guess what I wanted to say to both of you, that your testimony has been very important because you have given me more facts and more stories that I can put forward as I write this resolution because to unload this kind of a burden on the counties and to have a situation, as Mr. Cousineau very honestly said, where they are looking at your wonderful strides that you are making for prenatal care, saying that is wonderful, but what has happened to the rest.

That is an impossible situation, where we are turning one group against another. It is unacceptable. Obviously, we need to have prenatal care for every woman who needs it and every child who needs it, and we need to do that because it is the way to prevent the most damage, and it is the right thing to do, but here is a situation where as a result of this priority setting, there are other groups that cannot get health care.

A man who is suffering with diabetes winds up in an emergency room, stories in San Diego and Los Angeles that I heard were some of those in the emergency room in abdominal pain and it is appendicitis, and they are told to sit in the waiting room or come back later, and 40 percent of all appendectomies, I am told, in California are made with burst appendixes. Forty percent of those who come

into a hospital wind up having very serious operations because we do not have the resources.

So, to me, as a Member of Congress, it is unacceptable that we have a situation where we are turning one group against another forgetting basic health care that everyone deserves, and it is a horrible situation to hear that kind of a problem where we are not together, where we are almost turning on each other, and that is unacceptable, and it is unacceptable that 53 percent of the kids in this county are not getting their immunizations. That is unacceptable.

I urge you to get a little more angry about the situation. I just do not think we can allow the Congress to think that the counties are willing to accept all this, and I do not think this President who says he is kinder and gentler should be shielded from hearing this.

I can assure you that both of your comments will be circulated and will be part of my testimony as I put forward some of this legislation on health care.

I want to thank both of you very much.

Mr. GATES. If I might briefly comment regarding immunization, I think we need help in funding the immunizations themselves, but our patients are not nice, neat, tidy patients. They do not understand. They need a lot of educational support.

Mrs. BOXER. That has to be brought out.

Mr. GATES. They need—we need well baby visits so that the mothers are coming in for some other reason and we can get them their immunizations, and it is not just the funding of the immunizations themselves, it is the whole array of——

Mrs. BOXER. I understand, but I look at the immunizations as the opportunity to have a very simple, straightforward program for the mothers——

Mr. GATES. You are absolutely right.

Mrs. BOXER. Which says you must bring the child in in x number of weeks. Then, when the mother comes in, she gets educated, but I think the notion of saying this is something that must happen, we must get this done, but you are exactly right, immunization in and of itself is not the be all and end all, but I think it is a way to take this issue to my colleagues in the Congress, to say to them, we will never meet the Surgeon General's goals for immunization unless we move now.

Now, that is the first step. You get the book. Once you get a woman in with her baby, the doctor has an opportunity to explain to her the other things she needs to do, but I am not under any illusion that funding childhood immunizations is the answer. It is, however, one simple thing.

You know, when you talk to my colleagues about the health care crisis, they glaze over a lot because it is such an enormous horrible problem, and that is why I think to be successful is what you have tried to do. For example, you have taken one serious problem, physicians cannot get paid on time and, therefore, they are turning away from MediCal.

Certainly there are 10 other problems that they have, but you have zeroed in on one problem. You have become an intermediary and you have given them their money, and, therefore, they are coming forward into the program.

Now, if you said to me, yes, I did that, and I said to you, but there's more of a problem now, but what you did was a very simple thing, and you have brought physicians into the program.

What I would like to do is do a very simple thing, which is have this immunization program. It would be a guaranteed program. It would be the first guaranteed health care as a right program for a child, and I think if we make it work and we keep it simple, I think we can move forward.

Welcome, Congresswoman. How excited I am to see you here. Will you come and join me up here, please, because Mr. Dymally had to leave for a health care appointment? It is just wonderful to see you and congratulate you.

We have just had some very important testimony from the county of Los Angeles.

Ms. WATERS. I know them well.

Mrs. BOXER. Yes, you know them well. And we are hearing the shocking statistics you also know well, that 52 percent of the children in Los Angeles County do not even have their immunization shots, and that we are not reaching the people we need to reach, and we have a lot more to do and the Federal Government has abandoned its commitment that it had a long time ago to indigent health care and both of these witnesses, I was just thanking them.

Mr. COUSINEAU. Mrs. Boxer, may I make one more comment?

Mrs. BOXER. Yes. I wish you would, yes, Mr. Cousineau.

Mr. COUSINEAU. To close out.

One of the problems identified, we have a very small parity program in which we try to increase access for pregnant women in the downtown area into some private and public clinics.

One of the things we found is that even if we can cajole sometimes and really force people to take doctors and hospitals and clinics that pay people who are pregnant, sometimes they will not then provide care to children once they are born and the rest of the family.

The MediCal system has been—the changes that have occurred have allowed increased access for prenatal care, but somehow we have got to change it so that the entire family is covered for a certain period of time, so there is not this fragmented system. You go in, the woman is pregnant, but I am sorry, you will have to—we cannot take care of your sick child because there are stickers sitting on somebody's desk, you know, across town.

So, that problem really needs to be addressed in sort of a universal entitlement program for the entire family up to a certain age. Something that reduces the fragmentation.

The only problem is that a lot of the private physicians and hospitals will not see a woman who is pregnant unless she has the MediCal stickers in her hand, and in terms of providing the delivery but extending that to prenatal care and allowing the clinics and private physicians to get involved in that would also be extraordinarily helpful because there is some money that has to be in some of the private sectors, which a lot of them are prenatal care providers could see more women, and I think they would, if they had a system that would work for them.

Mrs. BOXER. Thank you both very, very much, and I really will use you as resources as I move forward on my immunization reso-

lution, and I am going to talk to Congresswoman Waters about getting involved in that as well.

Talking about a guaranteed immunization program at the Federal level that travels with the child.

I would like to ask the Congresswoman-elect, she will be sworn in shortly, if she would like to make an opening statement.

Ms. WATERS. Actually, I wanted very much to be here with you, Congresswoman Boxer, to say to you this is important work that you are doing, and that I am delighted that you have chosen our community to hold this hearing in because all of us elected officials and decisionmakers are concerned about the health care needs of this community.

We have watched a deteriorating system for some time now. We know that we need additional resources. We understand that the Federal Government certainly has a role to play.

Hopefully, the State will do a better job of assuming its responsibility, but the fact that you are here focusing us all on the needs of children at this particular time means that we have the opportunity to see what we can do in the very near future to get State and Federal Government together to make a real commitment to children and basically set the goals.

This goal of 100 percent immunization is a wonderful goal to have, and I am just delighted that you are providing some leadership for us, and I look forward to working with you and anybody that I possibly can, and I see from the hearing today that you are starting right where we need to start and have some of the people in the room that can help us to force this program and to get a top priority.

Mrs. BOXER. Thank you so much.

Today, we have found out that the infant mortality rate in Los Angeles is just going the wrong way. I am sure you are not that surprised to hear it.

Ms. WATERS. Probably heard from Dr. Xylina Bean about what is happening.

Mrs. BOXER. We did not, but she——

Ms. WATERS. Is she here?

Mrs. BOXER. We are hoping she will show, and when she does, we will put her right on the stand, but she is not here yet. So, I hope that she will be here shortly.

But we have got problems, and the kids are our future. You know that, and, so, we have got to move it forward. Thank you both very, very much.

Mr. COUSINEAU. Thank you.

Mrs. BOXER. Panel 2 is Sylvia Drew Ivie, Executive Director of T.H.E. Clinic for Women; Ms. Shibata, Director, Asian Health Project, Past President, Asian Pacific Health Care Venture, Executive Officer, Association of Asian Pacific Community Health Organizations; Dr. Martinez, Executive Director, El Centro De Amistad, Professor of Psychology, Pepperdine University; Fern Seizer, Executive Director, Venice Family Clinic.

Some of our witnesses may be having a hard time finding us. So, we will just proceed with those who are here and as the others come, we will put together a panel at the end.

Ms. Ivie, welcome, and why do you not begin?

STATEMENT OF SYLVIA DREW IVIE, EXECUTIVE DIRECTOR, T.H.E. CLINIC FOR WOMEN

Ms. IVIE. Thank you very much.

You have been hearing from two individuals who have given you sort of a micro—macro picture of what is going on in Los Angeles County, and I would like to share with you some of the perspective and microscopic context.

T.H.E. Clinic for Women is a medium-sized clinic serving minority women in southwest Los Angeles since 1974. We are delivering now about 600 prenatal patients a year, which is 0.3 percent of the number that Mr. Gates just quoted being delivered in Los Angeles County.

Mrs. BOXER. So, there is 50,000 that his——

Ms. IVIE. 200——

Mrs. BOXER. 200,000 every year, 50,000 through the county and you have 600?

Ms. IVIE. We have 600 babies, and we are taking care of just about that many children during the course of the year.

Despite the smallness of our efforts compared to the need that is there, I think you will find that T.H.E. Clinic provides a model that could serve as a model for what should be done to take care of the problems that we are encountering, and what I have tried to do in my testimony, my written testimony, is to list for you the things which work in our context, and then those things that are problems for us in providing the kind of primary health care that is needed.

The things that work for us which are not found throughout Los Angeles County, throughout the State, throughout the Nation, are as follows:

If you are going to serve poor people in Los Angeles County, you must have the staff of people that reflects who those people are. We have a staff, a medical staff composed of African-American physicians, nurses and medical assistants, Koreans, Latinos, and Chinese. So, we have a multiethnic medical staff.

We have a multiethnic health educator staff. Mr. Cousineau was just talking about the need to complement your immunization services with health education services. You do not have to be a brain surgeon with 16 years of Harvard education to help a young woman understand what the immunization needs of her child are, but you need somebody who will do it, who can identify with that woman, who can understand who she is culturally, who can understand who she is economically, who can understand who she is educationally, and I think one of the greatest strengths at the community clinics is that we have a staff, we have more health educators than we have anything else. We have more health educators than we have administrators. We have more health educators than we have doctors.

These are the people that make it work. These are the people that the patients trust and rely on and call and say what do I do now, where do I go now.

It is paid peer support, and I think that structurally is something that Congress should be investing more dollars in.

You asked Mr. Gates about outreach. We do very effective outreach because we target our three communities, really more than

three communities, black, Hispanic and five or six different Asian Pacific communities, by the outreach which we have found works in those different communities.

We do a lot of radio advertisement for the African-American community. We do a lot of outreach in the church for the Latino community. We do a lot of outreach in community newspapers for Asian Pacific patients. You have to constantly tell people that your services are there, that they are there in their languages, that they are being provided by people who are sensitive to who they are. It does not just happen that you put the service out there and they come. Outreach is just a critical component of that.

Then, when you get the patients in for primary health care services, it is critical to seize the opportunity to do education that goes beyond the immediate medical need. We do training on battering. We do training on smoking cessation, self-esteem, financial management, parenting skills, and such risk factors in living conditions as lead poisoning.

So, once we get them in, we do not let them go. We take advantage of the time to do some not exhaustive but this is the only opportunity they have to avail themselves of that education.

Another important factor in our structure is integrating the services for the one body. We get a woman who comes in as a family planning patient. We keep her. We keep her when she comes a prenatal patient. We ask her to bring her children in for pediatric services. We inquire whether her parents and her grandparents are getting care, ask them to come into our clinic.

It is one family, and if you work through the woman, it is our opinion, it works the best, and if you give her a place where she can get integrated services and take care of her whole family, then you are really getting primary health care out there in the community.

Finally, we are trying to help with the tremendous financial problems that our patients encounter. Most of our patients are uninsured. By working with MediCal now, we have an out-station, MediCal out-station, worker in our clinic, but it is not enough to have the out-station worker. Our staff has to translate for her in all the different languages that we need, and more than the translation, you need an advocate to help with the paper work. You know, you need this piece of paper or you cannot be eligible. You need this piece of paper, you need this piece of paper and somebody has to help the woman get all that together, particularly if she is a new arrival in this country and this is just extremely confusing.

Now, what are the impediments in our clinic? We have what we consider to be an excellent model for primary health care, health delivery. The impediments are transportation. People cannot get to us from all the different parts of the county that they need to get to us. They do not have the money, the public transportation system does not work to get them there at the time they need to get there, they do not have cars. Transportation is a tremendous problem, and it is one which no one, private or public, has really addressed.

Now, we take care of senior transportation needs to some extent. You know, you can call up and get a ride to go to the grocery store. You can call up and get a ride to go to medical appointments, but

we do not do anything for the mothers with two or three small children at home. How are they going to get in to get their birth control pills so that they do not have the fifth child when they are not ready to?

How are they going to get in to get the children the shots that they need? It is not a very glamorous issue, but it is an absolute impediment to their getting to care. They want to come to care. They call us. I cannot get there.

Absence of funded support for teens. This is a tremendous impediment. We have in our clinic 26 different sources of grants, but not one of them pays for provision of services for support work for the teens that are in our clinic. Teens have every problem that you can shake a stick at, and the health care provider is the opportune place to give them support for all of those issues, self-esteem, peer pressure, resisting, gang involvement. All of that can be done at the same site when they come in for their STD checkup, for their birth control pills, for their prenatal care, for their babies, but no one pays for that, and the Federal Government, it seems to me, should do that.

When we had our tremendous cuts by the Governor last year in family planning, which were reinstated by the legislature, the thing that fell by the wayside from that were the support programs for the teens. Teen education and outreach was cut out and not restored.

Another problem that we encounter, we are a clinic primarily targeting women, but all of our women virtually have partners who need care, and there is not a mechanism that exists in this community, and I do not believe there is a mechanism in the State or the country, that addresses the parallel needs of adolescent males for health services.

Adolescent males need a place where they can come and feel safe and feel protected with confidentiality for STD checkups, to get condoms, to learn about the reproductive health system of males and females.

If we have a young woman come in who has an STD, we invite her partner to come in, but it is a very intermittent kind of service. We need to address the needs of young men for their own health services.

Another point I wanted to share with you was just the high cost of immunization. I have attached to my testimony some numbers that show how much the different vaccines cost, and I think you should be aware of the fact that while one shot of one particular vaccine might not be expensive, cumulatively, if you give the child all the shots the child is supposed to have up until 15 months, that is a $155 just for the vaccines, okay. That does not include the needles, the syringes, the staff time that is required.

For a provider of care, that means that we have to make that investment in purchasing that quantity of vaccine, which is hard for us to do because we have cash flow problems as all community clinics do, and for the parent who is above CHDP levels, that is a completely different amount of money. She does not have a $155 to put out for shots.

So, cost really is a factor, both to the providers of care and to the patients who are not covered by MediCal.

Mrs. BOXER. So, if this woman under my idea had a book and we will take it that we can do the education and she is able to take that to you, to your clinic or to a county, wherever she chooses to, and with the $155 worth of coupons——

Ms. IVIE. Yes.

Mrs. BOXER [continuing]. That she would have, it seems to me it might be an exciting concept where she could walk into your clinic, present that, now have her do other things. You know you are going to get covered for this immunization cost easily.

Ms. IVIE. Yes.

Mrs. BOXER. I think it would be exciting idea.

Ms. IVIE. Yes, I think that would solve our problem entirely.

Mrs. BOXER. Yes, because I feel what you are pleading for is to say, look, Federal Government, we are an opportunity here, we have a chance at getting—and you are all, I think, going to perhaps repeat the same story, we have an opportunity through our reach-out and the kind of place we have that does not threaten people and makes them feel wanted and so on, of solving a lot of social problems.

The main thing is to get people in the door and help us keep our doors opened, and I think that is essentially what you are saying.

Ms. IVIE. Yes. But another important limitation of the kind of service we provide is that in our prenatal program, we do not have a delivery capacity. We take them from as early in their pregnancy as we can get them in to 9 months, but we do not have a bridge into the hospital system that Mr. Gates described.

So, what happens is we have a contract with UCLA where they send residents to take care of our prenatal patients, and they give us 10 beds a month, well, 50 of our patients deliver a month. So, 40 of our patients are on their own to find a place to deliver, and some of the deliveries are just shocking.

Last week, we had a patient deliver in an extremely overcrowded private facility where they were so backed up with patients that she delivered the baby and was sent home before she had delivered the placenta with a fever. So, she came back to us and said I will never go back to that hospital again, but, of course, that makes us feel horrible that we have no capacity to keep the next patient from going to that same hospital next week because the 40 are on their own every month, only the 10 have a reserved space.

So, something has to be done to bridge the good prenatal care programs like T.H.E. Clinic to get those not only well-cared-for for 9 months but to get them to a good hospital and get them the care for delivery.

Mrs. BOXER. Absolutely. It is a very mixed message to give someone to say how important it is and how critical it is and you teach them that and then they have no place to have a baby.

Ms. IVIE. Yes.

Mrs. BOXER. Outrageous. So, you need more slots.

Ms. IVIE. More delivery, yes.

Mrs. BOXER. Thank you. That was excellent testimony.

[The prepared statement of Ms. Ivie may be found at end of hearing.]

Mrs. BOXER. Ms. Shibata.

STATEMENT OF KAZUE SHIBATA, DIRECTOR, ASIAN HEALTH PROJECT, EXECUTIVE OFFICER, ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATION, PAST PRESIDENT, ASIAN PACIFIC HEALTH CARE VENTURE

Ms. SHIBATA. Good morning.

Mrs. BOXER. Good morning.

Ms. Shibata. I am the Director of Asian Health Project and T.H.E. Clinic. So, I basically work for the same organization, I work for Ms. Ivie, but I have been asked to speak on behalf of Asian Pacific Community today in Los Angeles County.

I just came back from Washington, DC, yesterday, and as you know, in Washington, DC, the definition of ethnic minority is very, very limited and, of course, the people in Washington, DC, have very limited exposure to Asian Pacific community and, therefore, definitely lack of awareness in terms of who we are as a group and people.

I am here today to speak on behalf of the diverse communities, Asian Pacific community, in Los Angeles, which is approximately 1 million of us, which makes our Asian Pacific community the largest in the United States.

Our community is very diverse, that there are at least 30 different Asian Pacific ethnic groups in Los Angeles County. There are approximately 10 major Asian Pacific groups measured in terms of population, Chinese, Korean, Japanese, Thai, Laotian, Filipino, Tongan, Vietnamese, and some more, if I am not missing anyone else.

Asian Pacific Islanders in Los Angeles are often chastised as very recent arrivals, refugees and immigrants. Approximately 75 to 80 percent of our population. The diversity of the population and population growth makes it very challenging in terms of how the health care delivery model should be formed in Los Angeles County.

In fact, the population growth—despite the population growth and the socioeconomic barriers of our community, there are only three community clinics that can address bilingual/bicultural services for the Asian Pacific community.

As Mr. Gates spoke, the Los Angeles County Health Department through its centers are not capable of providing some of the basic health care services in a very culturally and linguistically appropriate manner. So, what happens in a community that is locally staffed, for example, the staff people have to take our Asian Pacific patients into account in the facility with translation services, and it is—for community organizations.

Once a person is referred to county facilities, the county facilities have to be responsible for the patient, not us, but, you know, since we care very much about our patients, we introduce our health educators to companies for Asian Pacific patients for translation and interpretation services, which, in a way, depletes our resources.

Now, what we need in terms of children's health and health of people in our communities, oftentimes this is typical in Washington, DC, too, that we are portrayed as a well minority and very healthy ethnic group, despite the fact that we have serious health

issues and problems in our community, and I guess the conception of that—misconception of the community partly comes from lack of data, lack of research and lack of advocacy.

As you mentioned, that our immigrant and refugee population, because of their political skill as well as their representation skill, we cannot speak. I am one of the fortunate people who are given this kind of opportunity to speak, but a lot of our people are now being deprived of the opportunity to speak up and speak on behalf of their communities.

Now, specifically, to talk about health problems, one is the lack of child and child health services, targeting our communities. More than 40 percent of Asian/Pacific Islander women with the unintended pregnancy use unreliable family planning methods.

According to family planning, only 0.2 percent of the Asian women in Los Angeles County utilize existing Los Angeles family planning clinics. So, there is a definite lack of outreach and education services to our community.

The life expectancy of certain Asian Pacific groups are a lot lower than the U.S. average. Japanese, Cambodian and Laotian community, in particular, demonstrate low life expectancy of 40 to 50 years. The average life expectancy of a Laotian community is only 41 years, while the U.S. average is 50.

This is expected that the high incidence of infant mortality and low birth weight associated with the low life expectancy of this particular group. The percentage of low birth weight among Asian Pacific babies in the United States is 6.5 percent in 1980, higher than the rate of 5.6 percent. The percentage is higher among recent immigrants and refugees, ranging between 8 to 9 percent.

The Asian Pacific immigrant and refugee women tend to enroll in prenatal care very late because again of the lack of information and education, and it is estimated that 30 to 40 percent of the Asian women enrolled in prenatal care only in their third trimester or not at all.

Lack of prenatal care and the lack of day care services that are linguistically and culturally sensitive present child abuse and child problems in our communities.

Recent arrivals not having the family support that they used to be able to have in their native countries and having to work longer, a lot of times Korean and Chinese women in sewing factories in Los Angeles County, one of them worked between 12 to 13 hours a day, no breaks, because it is piece work. Every piece of clothing they make bring income to their family. A lot of times because of lack of child care services, they bring their kids to their working places, and the work environment is very, very poor.

So, I am sure I remember this Thai couple who came to T.H.E. Clinic about 3 years ago. They brought in a sick child. The baby was about 3 months old, high fever, demonstrated malnutrition. Both of them worked long hours. The husband worked in gas station, the wife worked in sewing factory. They did not know how to treat the baby properly because the formula was written in English and they could not read it, and they waited until last minute because they did not where to go.

Now, as I said, I just came back from Washington, DC, and I spoke with one of the providers in New York, kind of a health

clinic, and they are saying that they are facing a minimum of two- to three-family, mother-child abuse cases from Chinese community a week. So, you know, in the Asian Pacific community as well, they still have the idea that the family is very healthy, well integrated, very strong and so forth, but having to live in a society where we have been constantly adjusted to a new culture, a lot of times the family actually goes through a lot of stress.

There are a number of diseases in our community. Now, Hepatitis is up 17 percent in the population compared to 1 percent of the U.S. general population.

Mrs. BOXER. Seventeen percent?

Ms. SHIBATA. Exactly 17 percent of our community compared to 1 percent in the average general U.S. population.

Hepatitis morbidity is very high in Asians, being 35 percent. Of African-Americans, it is about 20 percent. Of Latino community, it is 11 percent, and 10 percent in Caucasian.

More specifically, the transmission is prenatal, and 90 percent is without proper—90 percent is infected without proper followup. Only 35 percent of infants born to women carriers of disease receive recommended treatment. Again, this goes back to Sylvia Ivie's point for lack of case management. The Asian Pacific population somehow falls into the cracks in health care system.

Now, our community, the Asian Pacific community, as any other community, value the importance of family and children. We believe in the next generation. However, our current health system and lack of health and human services make it very difficult for us to do so. Health care coverage is going to be needed for not only Asian Pacific Islanders but also for the people.

I would also like to bring up the importance of the maintenance and improvement of the community health centers and community organizations that are doing such a wonderful job, and I would like to urge you and Congress to allocate more funding to do a better job and allow the community health centers to do a better job for the special populations or else people are going to be covered but people will not have any place to go. Thank you very much.

Mrs. BOXER. Thank you very much, Ms. Shibata, and I would tell you since I do come from the San Francisco Bay area, I represent part of San Francisco, the huge Asian population, I know that everything you said is exactly true.

I have seen it myself, and as a matter of fact, one of our most interesting, newer programs we have is a drug treatment program for Asian Pacific Islanders, and people say how could that be. There is a waiting list, and I visited the program, and you are right, the stereotypes do not fit—no stereotype ever does, and this one is off the mark, and you have to fight that. I know that.

We have had to fight it with the University of California out there. We have had to fight it with programs. We have had to fight it with the Census, as you know, to make sure that we break down the groups so we know the needs and what we need to do.

So, I am very pleased that you are here today because it adds a very important dimension. Thank you very much.

Ms. SHIBATA. Thank you.

Mrs. BOXER. Ms. Seizer, we welcome you.

STATEMENT OF FERN SEIZER, EXECUTIVE DIRECTOR, VENICE FAMILY CLINIC

Ms. SEIZER. Thank you.

I am the Director of the Venice Family Clinic and wanted to tell you about the clinic as a community-based nonprofit State-licensed free clinic, providing primary health care without charge to low-income and homeless children and adults.

Since the clinic began 20 years ago, its mission has been to provide affordable, accessible, appropriate health care for those who have no other access to it. The people who are making 38,000 patient visits a year to our clinic have incomes below the poverty level and no health insurance. In fact, they do have no other access to care. They are medically indigent.

Although 92 percent of our patients have incomes below Federal poverty levels, only 6 percent have health insurance, including MediCal and Medicare. So, when you first thought that MediCal or Medicaid covers those people who need it, we have the statistics to say it does not. That clearly illustrates the great gaps that exist in health care coverage for the poor.

Medicaid program is not reaching the great majority of those who need it. As the State's Little Hoover Commission said last week, "MediCal constitutes an empty promise of health care to many of the 3.7 million who depend on it."

In addition to the 127 people a day we see, we are having to turn away many thousands more this year. Who are all these people who need our free clinic's care and who are served? Seventy-six percent are minority group members. Fifty-seven percent speak primary languages other than English. Thirty-nine percent are children and adolescents and 27 percent of the 38,000 visits are made by homeless people, a third of whom are children and—a third of them are children.

Why can they not get health care on their own? More than 9 out of 10 of our patients have family incomes below the poverty level yet they do not have health insurance. They are housekeepers, janitors, gardeners, restaurant workers. They are artists, writers, actors. They are illiterate and they are Ph.D.s. They are new immigrants and they are undocumented. They are former workers in businesses that went under. They are long-term unemployed, and they are between engagements. They are any of us who develop a major illness or a chronic disease for which we have no insurance coverage, who lose or cannot find jobs, who cannot make the rent payment, who are struggling to care for dependents who themselves have no insurance or support systems. They cannot pay for care in the private sector, and the county system in Los Angeles has established barriers that shut them out.

There are up front charges of $35 at county clinica, waits for many months for appointments, day long waits to be seen for acute care, overcrowded facilities, and continual and drastic cuts in services.

Last week a Superior Court judge ordered that $7.6 million in health care cuts be restored by the county, which had planned to cut an additional $12.7 million in medical services next month. The

judge found that these cuts unacceptably reduced the accessibility and quality of care with irreparable harm to patients.

State law mandates medical services for the poor be comparable to those available to nonindigent people, but as we have pointed out, that is not happening. The MediCal system limits patient access in many ways, including an unnecessarily complicated application process—the 17-page long form you talked about—inadequate reimbursement and long waits for reimbursement that result in fewer and fewer doctors and hospitals accepting MediCal patients. The county, faced with more and more people needing care and shrinking revenues, is cutting access to preventive care so that people are sicker when they finally get to the emergency room or are hospitalized.

What we have is a patchwork system of health care for the poor. There are some bright spots in it. The National EPSDT program screening children is one, and California, it is the CHDP program that has been extended through 18 years and is a model program, but we also need to be able to treat those problems uncovered in screening.

California has also taken the big step of including low income pregnant women as presumptively eligible for MediCal benefits, but only for health care related to their pregnancy. The problem of getting enough deliveries, as Sylvia Ivie pointed out, is true in our case, too. We have a terrific prenatal program, and we get 10 beds through UCLA's generosity. We could be extending that. There's a tremendous need, but there is no way to get additional deliveries at the county, and to participate in the comprehensive prenatal service program of the State, you have to plan where those deliveries will take place.

Mrs. BOXER. Let me understand this. You are providing at both clinics prenatal care to people who now under new law are eligible when they are pregnant for MediCal?

Ms. SEIZER. Yes, right.

Mrs. BOXER. So that presumably they could go find a bed somewhere?

Ms. SEIZER. No.

Mrs. BOXER. What you are saying is they are not because there is overcrowding or what is the reason that the hospitals, if they are getting reimbursed, is it too low a reimbursement? Is that what is going on?

Ms. SEIZER. Yes.

Mrs. BOXER. They only have a certain number of beds for MediCal so they just say no?

Ms. SEIZER. Private hospitals really do not want MediCal, and it is the county's responsibility to do it. The county is overburdened, but the county also will not say to us, all right, we will take the women for whom you have provided excellent prenatal care and we will guarantee them a bed. They will not do that.

Mrs. BOXER. Well, there is something in here that is wrong because if the State has said that the women are eligible for MediCal, they ought to have a right to have a bed with that MediCal coverage for delivery.

Ms. SEIZER. That is Alice In Wonderland rules.

Mrs. BOXER. There is some case out there for a group, I would think, to make because if it is the law and yet they cannot find a place to have this child, there is something very wrong. So, I am glad you are bringing this out. It is very important. Please continue.

Ms. SEIZER. Under IRCA SLIAG the Federal Immigration Act, those eligible for amnesty have health benefits and therefore access as long as the appropriations last. We think that was a terrific part of the bill. These are the bright spots and we want to encourage their continuation and replication, but there are gaping holes. Getting screening exams for children is good, but we need to be able to provide treatment, and just increasing access for children is not the answer if their parents cannot get care. Access to health care for working age adults, those between 18 and 65, when Medicare comes in, is the greatest unmet need. That was pointed out before.

Mrs. BOXER. Right.

Ms. SEIZER. Those who are not categorically eligible, for example, not blind or disabled, are without health care. We know what a difference providing that medical care to very low income adults has meant. We have kept people working, prevented the spread of communicable disease, kept people with chronic diseases from catastrophic illness, treated illnesses in early stages rather than having people show up acutely ill in overcrowded emergency rooms.

Overall, we have helped to build a healthier community. But ours is a private, community-based nonprofit response. We are part of the response to a great need, but that need is far greater than any one private system or really the system can meet.

The only effective response in the long run is a national health insurance system.

In introducing Concurrent Resolution 375 2 months ago, Congressman Henry Waxman called upon Congress to enact a national health program. His program includes the following characteristics: Universal access, comprehensive benefits, financing based on ability to pay, cost containment, a mix of public and private administration, quality and efficiency incentives, fair payment to providers, planning and evaluation, disease prevention and health promotion, and information on quality and cost.

We would agree with this approach, adding only a stress on allowing patients as much choice as possible. The health care crisis is growing. We see it in microcosm at our free clinic. Health care costs and lack of access are escalating, and the number of uninsured and underinsured people is increasing. We need a comprehensive approach that incorporates the best of what we now have and a promise of what could be to make a healthy community for all of us.

[The prepared Statement of Ms. Seizer may be found at end of hearing.]

Mrs. BOXER. Thank you. I think the three of you have painted a picture that I have seen over and over again in each community I have been in. I have been in Fresno, Modesto, Sacramento, San Diego, Los Angeles, San Francisco, Washington, DC, and in Washington, DC, we have people from all over the country.

So, I am getting a very clear picture of what is happening, and it is a very alarming picture to me, and if it was not for what you are

doing to try and fill in some of the gaps here, it would be completely disastrous.

I want to ask you all about the AIDS epidemic. Are you—do you in your clinics do HIV screening? Are you finding it a problem? Are you seeing more among adolescents? What is your analysis of where we are going with that crisis, if you can, and this is not scientific? I am just asking you anecdotally what your sense is about it.

Ms. IVIE. It is a very discouraging picture. We have been participating for a year and a half in a Centers for Disease Control study of HIV positivity, and we find as a result of that study that 57 percent of our patients are in an extremely high-risk group. They are high risk because they are engaged in behaviors which are high risk and they have multiple partners or they have had more than one STD in the past year.

So, their behavior is very high risk behavior, and their level of awareness of their risk is extremely low, notwithstanding an outstanding education and outreach program which is multilingual, multicultural.

So, the community of women that we serve really is not protecting itself, does not realize their level of risk, and it is a very depressing picture.

Mrs. BOXER. Do you try to do some counseling on AIDS when you are doing——

Ms. IVIE. Yes, every section of the clinic talks about the HIV risk.

Mrs. BOXER. Are some of your babies being born HIV positive? Do you track that at all?

Ms. IVIE. To date, I am not aware of any of our babies having HIV positivity, but we have had a number of HIV positive women who were not pregnant in the clinic, and we do counsel to all of the pregnant women.

Mrs. BOXER. Thank you.

Ms. SHIBATA. I believe the community of women in terms of HIV infection is at greater risk in terms of the definite lack of data and the lack of research. Most of the research for HIV has gone to the—what they call men, really focusing on male anatomy and physiology because the HIV first attacked the gay community and therefore a lot of resources have gone to that community and studies, and I really support that. There is still a need for such research and data collection for bisexual and gay community, but given the fact that there is an increasing number of positivity occurring among women and children, I think the research needs to be—the focus of the research really needs to change to address the changing HIV faction.

Mrs. BOXER. I am glad you brought that up. In Sacramento, we had a panel of women talk about this very issue and they are very distressed that very little is known.

As a matter of fact, when the first cases of pediatric AIDS came to our attention, we held hearings on that, and very little research had been done on how this disease is transmitted, and, for example, we did not even know until we had some tragedies that the breast feeding would transmit the HIV virus and just think of what we could have prevented had we had some information.

So, this year, we do have a study on pediatric AIDS and, hopefully, that will lead us more into a research on women, but this is true in every area, be it cancer, caffeine effects, all of that. Most of the research is done using male subjects, if you will, and we are way behind.

Ms. Seizer, you talked a little bit about the AIDS issue in Venice, CA. What is your sense?

Ms. SEIZER. We are seeing more now because we have an increasing homeless population, and in our clinic particularly, we are targeting the homeless patients with an AIDS prevention program. We are actually—one of our staff members, a health educator, goes into the exam room while the patient is waiting for the doctor. It is a perfect time to really talk about that particular person and how they are protecting themselves or what they value.

Often, if you are prostituting yourselves for drugs just to survive on the street, the last thing you care about is protection, and so, we need to focus on that and also give free condoms.

So, I think that is one strong target community, the homeless. The other is minority women who, particularly in our Hispanic population, young moms with children, simply are not culturally comfortable talking about or raising the issue of protection for themselves and would never discuss that with their husbands.

So, we are getting to them in the waiting room and in general while the kids play, the moms are getting health education and group discussions about AIDS' risks and protecting themselves.

I think prevention is really the area that we have to address. Community-based clinics are particularly good to do it because there is that overall sense of trust and acceptance of what the doctor or health educator has said.

I would like to add to your coupon book, which I love. The coupons would be great. We could start with a coupon for delivery of the baby in the first place, because that is our major and immediate problem.

Mrs. BOXER. I think you are right.

Ms. SEIZER. You know, you have got to deliver that baby, and the problem in immunizing babies comes not so much that you have to reach out, but if you work through community-based clinics and provide a coupon book, people could go wherever they want. We found that in conjunction with the medical visit, moms bring their kids in when they are sick, they bring them in the first year of their lives. You have got to get them there and give them the immunizations as part of their medical visits.

It is not enough to just hold a 1-day event out in the parking lot some place and say bring your children in because that is out there, and who are those people out there doing it and why should I bring my child in, but if you bring them in regularly to trusted clinics, you will get all the children immunized. What Sylvia Ivie has said, the cost of the vaccine is one thing but the cost of the staffing and the——

Mrs. BOXER. I think you need to build that into the reimbursement, and I am going to talk to Dr. Martinez about this bill and that may be the stress is on the community clinic as opposed to walking into a very cold public health hospital. That is not going to

get to our goal of getting people to understand the importance of health care prevention, et cetera.

So, almost as important as the immunization is using it as an opportunity to pull people into a caring health care system that understands that and that speaks their language.

Ms. SEIZER. People need community-based clinics that are open evenings and Saturdays as well as regular daytime hours.

Mrs. BOXER. Exactly, exactly. So, maybe we will be able to build it in and focus it into a program for the clinics. The community nonprofit or community-based clinics to do this function, and, for once, maybe you can get reimbursement for some of these things that you are doing, and it would be a start.

If we add delivery to it, it is a little bit more complicated, and that may be—we may decide to do that and/or we may just decide to keep the immunization out there as something that would be impossible for them to—what, are they going to argue with us on this.

It is right there. So, I may just do it as the model to push it through as a guaranteed health care for children as a first stage, and then add to it the prenatal care, the—I will ask Ms. Waters to take the lead on it. One will be the Boxer-Waters and hers will be the Waters-Boxer, and we will have bills that essentially give that guaranteed health care, but I think what you have taught me, and something that again I have learned over these last eight hearings I have held, is that this is an opportunity. It is a crisis.

It is a crisis of health care, but it is an opportunity to get people to feel comfortable, to get into a system, to talk to people who care, to get advice and counseling on their lives, and we may not have that chance again until the kid is of school age. That is another opportunity.

So, there are really two opportunities here to reach to a family, whatever the state of that family, be it the single mother or a more traditional family. The opportunity to reach out and embrace that family, and your clinic can do that at this very early stage. The school has a second shot at it, but if the child does not have the measles vaccine, he may be dead before he gets to school and that is what we learned in this measles outbreak here.

Those children, the families did not understand the necessity, and when you talk about cultural differences, as I read it as well, the need to reach people and explain things to them is critical. In Fresno, they had, I think, half of the measles deaths because the family felt that if you break the skin, you let the evil spirits in. They did not understand it. They lost babies and it cost a lot of money while we tried to save these babies.

So, we can make the cost position argument. We can make the healing argument. But all told, you people are on the front lines. You deserve our deep thanks.

Maxine, would you like to add anything at this time?

Ms. WATERS. No, I have no questions that I would like to ask.

I would just like to share with you that we are very fortunate that the women who are here today did come to testify all about the work of all these clinics, and I visited most recently the Venice Family Clinic.

I just want to thank you all for all the wonderful work that you are doing, and I know that you could use some help, and I really

do—I do not believe that people understand really what you are doing and the great services that you are providing, and I want to be of help in any way that I can.

Mrs. BOXER. And we will, and thank you.

I am going to tour your clinic at Venice, and I will go to yours if I am invited.

Ms. IVIE. We would be delighted to have you.

Mrs. BOXER. I would be very happy.

Ms. IVIE. Consider yourself invited.

Mrs. BOXER. Thank you so very much.

Our last panel, we have Michele Melden, staff attorney of the National Health Law Project, and you are going to be our panel because apparently Dr. Brown could not be here, and I do not know if anyone here is representing him.

Did any people who were not at our last panel, Dr. Bean is not here, however, this will be our last panel. We may have a very interesting final person to testify, a teenager, who has asked to speak at the panel, and if she does come, Ms. Torres, we will absolutely hear from her.

So, we welcome you, Ms. Melden, and why do you not proceed and tell us anything that is on your mind that you think we should take back to Washington?

STATEMENT OF MICHELE MELDEN, STAFF ATTORNEY, NATIONAL HEALTH LAW PROJECT

Ms. MELDEN. Thank you for inviting me here this morning.

I am a staff attorney with the National Health Law Program. The National Health Law Program is a——

Mrs. BOXER. Wait a second. It is hard for us to hear the witness. So. Is this Ms. Torres? Welcome. Come in. You will be glad to know that we will be very glad to hear from you. Please continue.

Ms. MELDEN. The National Health Law Program is a health law support center that provides legal advice and assistance to legal service offices and the poor people they serve nationwide.

We have extensive experience monitoring children's access to preventive care and women's access to prenatal care under the Medicaid program.

I understood my invitation was one to provide an overview on the state of health of African-American children, and, in particular, to address the cost and accessibility of health care for them.

My comments this morning will put some of the California statistics and situation in the national context, and also I will address much of my focus to California's Medicaid program and how it should be improved.

Over the past decade, as you know, Congress has attempted to address the problems of high-infant mortality and an increased incidence of preventable childhood diseases by making some important expansions in the Medicaid program.

Unfortunately, the experience nationwide has been a widespread lack of implementation and outreach, and these expansions, therefore, are not fulfilling their promise of improving the state of poor children's health and improving the infant mortality situation.

Many poor people are not covered under MediCal, but my focus this morning is going to be to talk about those who are and their persistent lack of access under that program.

It is true nationwide, it is true throughout California, it is also true in Los Angeles and in some cases even in Los Angeles. As you know, California's Medicaid program is called MediCal, and significant barriers exist within the program which are preventing eligible women and children from receiving much needed preventive care and prenatal care to which they are entitled.

One of the most significant barriers pointed out already this morning is the unwillingness of physicians to accept MediCal rates as payment in full. This is caused in part by low rates. It is also caused in part by California's failure to reach out to providers and inform them of improvements of rates and improvements in claims processing.

California has made important improvements for obstetric care, but you asked earlier what the global rate was. It is around $1,200, which is high compared to most other States, but participation is low still.

Mrs. BOXER. $1,200 reimbursement for OB/GYN under MediCal?

Ms. MELDEN. That is right.

Mrs. BOXER. That is very good, and that was recently raised.

Ms. MELDEN. It was raised a couple of years ago, and still provider participation is very low. Many do not know that the rates have been improved.

Also, California made some important improvements in claims processing. It is still hard, but they—physicians still do not know about them. The other problem with the rates, as somebody else pointed out, is that the obstetrical rates, while they are high, accompanying services, like anesthesiology and radiology, are not comparable, and we have heard a lot of anecdotal stories in California that anesthesiologists in particular are pressuring hospitals to put quotas on MediCal beneficiaries when they deliver, and I think that situation would be improved in part by raising those rates.

An additional problem with access is California's inadequate implementation of the EPSDT program. There were very important improvements made under OBRA 1989. California has on the whole failed to implement those improvements.

California also does not do a great job in reaching out to eligible women and their children to inform them of the availability of preventive care for their children and prenatal care for themselves.

In addition, there is a recent suit that is pending in Los Angeles challenging unlawful delays in processing MediCal applications. That is a huge problem. Not only is the form incredibly cumbersome, but even if people manage to fill it out, they do not hear within the time required by Federal law.

I also want to add that other panelists have pointed out problems with delivery. Women are not only having problems getting prenatal care, they are not finding hospitals to deliver their babies, and you were asking if there were some sort of legal handle on this.

One of the problems here is that California uses a system called a Selective Provider Contracting Program. California got a special waiver years ago, a few years ago, to operate this program, and what it does is it restricts women who live in certain geographic

areas to receiving all their services in a particular hospital, except for emergency services, and that is a system that is basically used to divvy out where the women are going to have—get their beds to deliver the babies.

The system was adopted to control rates and also purportedly to ensure adequate access. It is not doing that. The contracting hospitals and all the county hospitals and contracting hospitals are operating well beyond capacity, in fact dangerously beyond capacity.

The hospital in Torrance is apparently operating at 130 percent of its delivery capacity, and last summer, started refusing to admit women in labor and handed them road maps instead to other facilities.

I just want to point out today that that system is operating under a waiver and is up for renewal this month, and I want to urge that that renewal not be granted unless California shows it is ensuring adequate access which it is not.

Mrs. BOXER. The renewal is what?

Ms. MELDEN. It is a waiver to operate the selective contracting program.

Ms. WATERS. If I may, it is a program——

Ms. MELDEN. Please.

Ms. WATERS [continuing]. That is developed in the legislature as you said to control costs that many of us do not like. We developed what is known as the SAR to negotiate rates with institutions, and many of them come in and negotiate low rates and then they cannot perform based on the rates that they negotiated and they want to opt out of the system and leave people stranded or, like you said, over capacity, and they have to start sending people elsewhere.

So, it really is problematic, and I think you are absolutely correct, but I think in order to do that kind of reform, we really are going to have to get the members of the Senate and the Assembly who oversee it and the health committees to get involved in it and give some leadership to change the system and getting out of that system that was put in place about 4 or 5 years ago.

Ms. MELDEN. In my written testimony, I have the date that it was adopted.

Yes, I think that is true. There needs to be leadership there, and in some ways, this is a reflection of the greater problem, which is low rates and the unwillingness of private facilities to take these people.

So, there is a combination of these systems taking the MediCal recipients and at the same time being overburdened by all the other people who do not have access to health care, and this is just a system that is bursting at its seams.

The testimony that I have submitted/presented this morning concentrated a lot on the disproportionate impact on African-American children who are suffering in particular from California's attempt to implement the MediCal program properly.

But this is a problem that is occurring nationwide. According to a 1987 national study by the General Accounting Office, only 36 percent of women on Medicaid are receiving adequate prenatal care as compared to 81 percent of privately insured women.

According to a 1988 study, the California situation was comparable, only 30 percent of MediCal-eligible women are receiving adequate prenatal care.

The inadequate access is caused in large part as I said before by the low participation by providers and by lengthy application delays, and the result is high infant mortality and low birth weight rates.

Statistics indicate that in California, African-American children are suffering disproportionately. The infant mortality rate and low birth weight rate among African-Americans is twice that of whites.

In addition, African-American children nationwide are suffering disproportionately from communicable childhood diseases that we talked about and are really due to the lack of access to immunization.

They are also suffering disproportionately from lead poisoning, sexually transmitted diseases and AIDS. This situation is reflected in California and in Los Angeles.

Medicaid offers a unique promise of providing such children with access to followup care through the EPSDT program. As somebody mentioned earlier, in California, the program is called the Child Health and Disability Prevention Program or CHDP. Unfortunately, in our experience, California has failed to implement this program properly.

Studies have shown that fewer than 25 percent of eligible children are receiving their screens, and that means without those screens, they are not getting the immunizations.

Beyond the screens, they are not able to provide providers—they are not able to find providers. So, the CHDP program really is not delivering on its promise. The problem, as I said before, is low reimbursement rates, inadequate outreach to beneficiaries to educate them on its availability, and again lengthy application delays.

I want to point out some examples of the disproportionate impact on African-American children. As we said earlier, 50 percent of children in California are not receiving their immunizations. We have 50 percent of 2-year-olds who have not been immunized for DPT. Among African-Americans and Latino children, the figure is 75 percent; way out of proportion to their representation in the population.

A 1985 study showed that compliance with immunizations for entry requirements in Los Angeles County, here the greatest proportion of African-Americans in California is only 76 percent, lower than California as a whole, and the impact has been disproportionate on African-American children.

The CHDP program should be providing children with immunizations. It is not.

Similarly, the CHDP program should be providing lead blood assessments to detect lead poisoning. That is a requirement in the statute that was passed in OBRA 1989 for EPSDT. They should all be getting their followup treatment.

California has declined to provide lead blood assessments for the EPSDT program or CHDP. Again, African-American children are suffering disproportionately. According to a recent study, over 67 percent of African- American innercity children nationwide suffer

from excessive lead exposure. The result is permanent neurological damage if untreated and impaired educational performance.

Ms. WATERS. I am sorry. Where does the lead exposure come from? It is not in the paint anymore.

Ms. MELDEN. That is a misconception. It is still in the paint. In California, it is still in the paint. Even in Los Angeles, people think that because the housing is newer than it is in the East Coast, if you go back to housing that was built in the fifties, the paint that was used has excessive levels and it is getting—the kids are getting poisoning that way.

Ms. WATERS. That is the main source of lead poisoning?

Ms. MELDEN. I think it is, yes.

Ms. WATERS. Lead paint?

Ms. MELDEN. Yes. And it also comes through the water supplies to the pipes, and supposedly there is some schools that are having problems with that.

A recent suit was filed by my own office, other legal services offices and the Natural Resources Defense Fund challenging California's failure to do appropriate detection of lead blood poisoning and the followup treatment.

If you would like a copy of the complaint, I could provide that to you.

Ms. WATERS. Yes.

Ms. MELDEN. That has some of the factual bases for lead poisoning that is occurring.

As I said earlier, California is also failing to implement the new Federal requirements under the EPSDT program. One of those is that children are entitled to receive followup care for any conditions detected in a CHDP screen, whether or not the State Medicaid plan otherwise covers those services.

California is rejecting that. The MediCal program is limiting followup care to only those services already covered in its Medicaid plan in direct conflict with Federal law.

As we all know, inadequate access to prenatal and children's preventive care results in chronic lifelong physical and mental disabilities, and the impact on African-American kids is disproportionate.

The investment has proved to be cost effective. I am sure you have a lot of that documentation, and actually they are available to many of these children if California were implementing the program properly.

I just want to point out some numbers to you. You may have already heard these in other parts of the State, but there was a study done by Children Now, which studied access in California. These are the numbers they came up with. $1 invested in prenatal care saves more than $3 of children's medical care later. While prenatal care and delivery under MediCal costs approximately $1,200, the average MediCal reimbursement for a baby in an intensive care unit is $19,000.

Similarly, for each dollar invested in immunization, $10 in medical expenses is saved later.

My written testimony contains a number of recommendations on how California should improve its MediCal program to come into conformity with Federal law and to bring down high infant mortal-

ity rates and to ensure that eligible children receive necessary preventive and followup care.

Most important are improving reimbursement to expand provider participation, implementing the State's CHOP program in conformity with Federal law, and promptly processing medical applications.

If you would like to hear more about these recommendations in greater detail, I would be happy to answer your questions now.

[The prepared Statement of Ms. Melden may be found at end of hearing.]

Mrs. BOXER. Ms. Melden, I have a few thoughts as I listened to you, and I thank you very much for what you have done for us.

If I happen to go ahead with this bill, the Immunization Now Act of 1991, I am hoping my coauthor will be right here, Mr. Miller and Mr. Dymally and get us all on there, and we are going to present that bill as a cost saving measure because $1 spent on immunization saves $10. So that if every one of our children had guaranteed the immunization and we do it in such a way that the families get involved in health care, they go to community-based clinics for this, we have not only broken through the immunization problem but we have brought people into the system, and we are able to help.

So, that is one thing, and I believe that you agree it would be a good idea, I think, from your facial expression.

Ms. MELDEN. Yes.

Mrs. BOXER. But I want to ask you about two other things that you taught me today, and I am thinking about it now.

First of all, that you do not think the physicians in California yet understand that MediCal reimburses $1,200, and I am wondering if you do not think it might not be a bad idea for some of us in Congress to write to the California Medical Association, after all, it is to their benefit, and ask them to advise their members.

I mean, this would be a very minimal thing that they can put in a newsletter, and put the burden on the CMA to advise their people. So, that is something I am also going to do, is get some of my colleagues to go along and write a letter to CMA and say there is good news/bad news. The good news is this reimbursement has gone up considerably. The bad news is that you do not seem to know it, and can we count on you to let your people know.

Third, your point that many physicians will not take MediCal patients, and I understand some of the real reasons why. I do not want to seem too critical, but I would like to say this: It seems to me if a physician has taken advantage of the Federal Government loans for his or her education, there ought to be some obligation to give back, and I am going to ask your opinion on both these things, the letter to the CMA and this question, whether we ought to fashion some kind of legislation that would require any physician who has availed himself or herself of student loans to accept all Medicaid, we will use that expression when we are doing a national bill, patients until such time as that loan is paid back.

Now, we could do some incentives in there. We might, for example, lower the interest rate on the loan. We could discuss that maybe with the CMA, but I wonder if you think there is room in

here for some kind of an idea because we are facing a horrible problem with physicians not taking MediCal patients.

It seems to me if they have been on the dole themselves and gotten assistance in getting their education, they have some obligation to help others who are not—in other words, the Federal Government was there for them when they needed help, now there seems to be need to be where people need them.

Ms. MELDEN. Both of those recommendations are good. One, that you send a letter to the CMA, I think that that is a great idea, and actually there was a settlement agreement in the last couple of years in which California agreed to expedite claims processing and make other improvements, and part of that settlement agreement was with the State and the State had the obligation to reach out to inform providers, and I think it has to be done by both. It has to be done by the CMA and the State to work together.

I also want to add that part of that settlement agreement was to improve claims processing, and I think it would be very helpful if the CMA were to send out a letter saying the rates have improved, also that they could take that time to educate the provider on how the processing system has improved.

But added to that, the claims system still can be difficult, and we think that the State should also be doing a better job showing how physicians can do the processing so it works.

I mean part of that is quite intentional. It used to be that California would decline any claim by a physician if there was one mistake, send it back, the physician would fill it out again and then find another mistake. They go for one mistake at a time. They agreed to look for about three mistakes at a time, which will help a lot.

Mrs. BOXER. Well, do you think the people who administer this program like this program? I mean are they trying to undercut it/undermine it? I mean that's——

Ms. WATERS. The fiscal intermediary for the State of California, I believe, saves money for the State by abusing physicians in the program and delaying their payments. I really do think that it is intentional.

I have said that for quite some time. I asked the CMA to come up with a program to assist physicians in the billing process, also. I do believe that they can do a better job. I think that under OBRA, that is deserved and that it should be used to assist physicians in the claims process because I think that some of them could be better, but the biggest problem is with the fiscal intermediary that kicks the claims out one by one as you said and literally avoids having to pay the physicians so that they save money, and I think it is a horrible system, and I do not know why the doctors have not done more about it.

Let me just say on those occasions, Congresswoman Boxer, that in the notification of CMA, there are some other associations that are basically minority associations like the Charles Drew Society/Association and the Golden State, and then there is one—I think there is one with Physicians or something like that or Women's Physicians, that we should also notify because some of them are not as involved with the CMA as we would think and they kind of get their information in other ways.

So, I think those are excellent suggestions, but, really, the problem with the fiscal intermediary really must be dealt with.

Mrs. BOXER. I agree, and you are such an expert at that. I am very unfamiliar, but having served in local Government, but I missed the State Government, and Congresswoman Waters brings that experience and it is going to be absolutely critical because it is all—it will not work if we do not have cooperation from the State legislature, but it does sound like they are so—the intermediary is—the fiscal intermediary has a job to save money, and it is making a system break down, and that is unacceptable.

What about the other idea of having physicians who have gained the benefit of Federal loans, requiring that it is a necessity that if they do avail themselves of such loans, that they need to pay back by seeing Medicaid patients?

Ms. MELDEN. I would support any movement to make—to impose conditions to accept Medicaid-eligible patients. I think that is terribly important, and it just so happens that in OBRA 1989, Congress passed—actually codified a previous regulatory requirement that the rates be sufficient to enlist adequate numbers of providers, and HCFA is in the process now of developing criteria for determining whether States are doing that.

One of those is by looking at the rates in relation to the private pay rate, but another is by looking at the participation levels of providers, and one criteria that they have suggested is whether 50 percent of the providers accept any Medicaid patient who walks through the door, and there may be some way of working together to do that.

I think that it is a complicated question. It is going to be complicated because you are going to have to decide how many is enough, how many satisfies that condition. If you see one person once or you give them continuous care, if you see all members of the family.

In my work in the National Health Law Program I get, you know, very sad telephone calls about, you know, physicians from small communities who will only see children. So, a mother who has brought the child for years to the physician, this physician is turning her away. So, you have to see how you can allocate that.

Mrs. BOXER. Well, those rules and regs as we learned in Congress will be drawn up and there will be hearings on them, but I think the concept of some return to the community for getting help when they were down and needed help is a concept that a lot of Members of Congress have talked about, but we have never really sat down and directly addressed it.

So, I can see that you feel that although we cannot spell out all the parts of it today, the concept is one which you think is a good one.

Ms. MELDEN. Yes, and I do. I agree very much with that idea of paying back when they were getting help from the Federal Government, and also I think that could be broadened. The Federal Government provides a lot of support for medical education in other ways.

Mrs. BOXER. Yes.

Ms. MELDEN. They do a lot of funding of the universities.

Mrs. BOXER. Absolutely.

Ms. MELDEN. And I think part of that really supports the medical education that doctors benefit from.

Mrs. BOXER. That is a very good point. So, even if you did not avail yourself directly, the fact is your medical school is more than likely getting Federal grants. Well, I think that is a very good point.

Unless the Congresswoman has any other comments, we want to thank you very, very much. You are on the ground fighting this battle, and we appreciate it.

Ms. MELDEN. Thank you.

Mrs. BOXER. And now for our last witness, we could not be more pleased to have a teenager from Los Angeles area with us, Ms. Torres. Would you come forward? We want you to just tell us some things about the health care and a message that we can take back to our colleagues in Washington.

Just proceed and feel comfortable.

STATEMENT OF KENNIA TORRES, LOS ANGELES, CA; ACCOMPANIED BY RUTH BEAGLEHOLE

Ms. TORRES. My name is Kennia Torres, and I am 17 years old. I attend Business Industry, and I have a 2-year old son who also attends Business Industry along with me. Back in 1987, I was taking the INH tuberculosis, and I showed positive in my junior high school years, and then I only took them for 3 months, and then after that, they discontinued them because I had no interaction with them.

So, the years went by. It started affecting me more and more, and I did not know until I started getting these terrible side pains, and then they thought I had Hepatitis, and they drawn blood out of me and they gave me a long dose. They gave me Compazine, and I had a reaction to it, and my whole body numbed and my face, I could not move, and then I was rushed to the hospital, and they could—I sat there for an hour and I could not see the doctor because he did not have any beds available at the——

Mrs. BOXER. You are on MediCal?

Ms. TORRES. No. At that——

Mrs. BOXER. No insurance whatsoever? Just uninsured?

Ms. TORRES. At that moment, I did not have MediCal.

Mrs. BOXER. All right.

Ms. TORRES. So, then, as the years went by, I had my son when I was 15. I went to live on my own. I was 16 and then I got him on MediCal. So, anyway, even with MediCal, I had to suffer a lot with him because he was allergic to any kind of food. He is extremely—he cannot drink cow's milk because he was just a big mess.

Mrs. BOXER. Allergic to milk, did you say?

Ms. TORRES. Yes. Cow's milk.

Mrs. BOXER. Cow's milk.

Ms. TORRES. And I did not know he was that, and then once I took him to the doctor and he said take him off the cow's milk, put him back to the formula, and I did not know what to do with this baby because it was—I asked for help and they just said do not give him milk, what am I supposed to feed him, and just give him juice, and then I did not know what to do, and I was so devastated that

when I enrolled in Business Industry, I told having it with my baby there, I did not know it is wrong, and then she told me that maybe go to another doctor and see if he could drink soy milk, and I could not manage with it because they could not—they did not give me the right information that I needed.

I wanted information about, you know, what sort of food besides cow's milk, what kind of soy milk because there are some imitation soy milk and there is good soy milk, and——

Mrs. BOXER. You are an expert now.

Ms. TORRES. I am an expert now. What kind of soybean and stuff like that. So, I just went for a whole year without information about my baby's——

Mrs. BOXER. Did you feel comfortable going to a clinic or had you found anybody——

Ms. TORRES. No, because I used to take him to Clark Hudson, and all they would do is bring him back in 2 weeks and if his diarrhea is gone, never mind, and bring him back in another 2 weeks, and bring him back in a month, and bring him back when he is 18 months, and it just kept on going and going and I never got the information that I wanted because they did not give you a permanent doctor. It was just whoever was on duty at those hours, and I had——

Mrs. BOXER. The hospital?

Ms. TORRES. The Clark Hudson is a clinic. It is public, but then at the same time, they are making it private. Only people who can pay cash, and even though you have MediCal, they give you different story. It used to be $40 for the immunization. So, say never mind and now I am starting to take him back to Children's and myself also because—now back to my problem.

I have Hepatitis and I did—then they said it was my kidneys. So, they gave me kidney pills and then they gave me this little pink for the pain, and it was not about a month that I was taking those pills and then when they were gone, I had the pain again, and there were these terrible pains like you feel if you are going into labor, contraction pains, you know. The nerve made it go all through the stomach, that is where the pain comes, and I used to throw myself on the floor because I could not get up and then after I had those pain pills, they were gone, I kept going back to the Martin Luther King and all they could say is just drink eight glasses of water a day and that will do it, and I got tired of drinking water. I used to take tanks to school, my gallons of water, bring it along on the bus with my baby, with my books, and I just got tired of water, tired of drinking water, and because every time it was time for parenting, I had to go to the rest room with all that water, and she said bring your potty along and, no, I got embarrassed.

And then, now they really found out what I had, so they said I had walking pneumonia, and that is due to the type of thing I never got treated for for years, and there is two types of medicine that it and that is the INH tuberculosis and another one and I need both of them, and one of them, the MediCal covers and the other one costs $220, and I did not know that medicine cost $220 until a friend of mine went to get—to the pharmacy for me.

Mrs. BOXER. For a year, $220?

Ms. TORRES. No. Just for the prescription because you need to——

Mrs. BOXER. For you?

Ms. TORRES. The container lasts for about 3 months and then again 3 months and then——

Mrs. BOXER. So, about $220 for a 3-month supply?

Ms. TORRES. Yes, but I did not know it cost—the doctor did not say anything, and then I have to beg my social worker from the county office. Like I have to beg her, and like I have to have an emergency, emergency medical card, she said all right and I have to miss a whole day of school just to get that card because if it is really busy, they will say you have to just sit down and wait, sit down and wait, and they have you there till 4 o'clock.

Mrs. BOXER. So, let me get this straight. You are 17.

Ms. TORRES. Yes.

Mrs. BOXER. You have a baby who is 2 years old?

Ms. TORRES. Yes.

Mrs. BOXER. You have tuberculosis that you are treating now?

Ms. TORRES. Yes.

Mrs. BOXER. And you are going to school, trying to finish school.

Ms. TORRES. Yes.

Mrs. BOXER. So, you are trying to take care of the baby by yourself, take care of your tuberculosis. You are an extraordinary person. You are an extraordinary woman.

Ms. TORRES. I just try.

Mrs. BOXER. Do you live alone?

Ms. TORRES. Yes.

Mrs. BOXER. With the baby?

Ms. TORRES. Yes, since I was 16 because——

Mrs. BOXER. Quite a story. And, yet, what you are telling us is that you had no help with your health problems. That made life even more difficult.

Ms. TORRES. Yes.

Mrs. BOXER. You had to go from place to place, not one physician would see you, so they would misdiagnose you. They even gave you a prescription for a pill that is not covered under MediCal and you have to beg your social worker to get it for a 3-month period.

Ms. TORRES. Yes.

Mrs. BOXER. It is really an incredible story. What you are telling us, by giving us this example, is that there is no system out there that is really helpful. Who is helping you the most in your life right now?

Ms. TORRES. What do you mean?

Mrs. BOXER. Who is helping you? Is there an agency that is helping you? Is there a person who is helping you the most? Is there a family member? Who do you call on when you need help right now?

Ms. TORRES. Well, this case worker at Children's. Her name is Becky. I met her through Ms. Beaglehole and——

Ms. BEAGLEHOLE. Project 19.

Ms. TORRES. Project 19.

Ms. BEAGLEHOLE. Project 19, which is Adolescent and Family Life Program at Children's Hospital. It has case management. I referred her for case management because I felt she was somebody

who needed, you know, a case manager to help her deal with the system.

Ms. TORRES. And, so, finally, I called her up and told her what was going on and she made me an appointment at the clinic and she said that if I am going to get MediCal now, but I have to go back to the county office and say I need another one for so on and so on months. If I say I need one for December, then I have to go and apply for one.

Mrs. BOXER. One what? I am sorry.

Ms. TORRES. MediCal card.

Mrs. BOXER. MediCal card?

Ms. TORRES. Yes, but now she is saying my residential card. It is three stages. It gives you permit to work and then it gives you a temporary resident and then they give you the white final card, and on the white final card, on the back, it has this number, this serial number, that says I am not entitled to get no MediCal and no AFDC in—even if I apply for myself.

Now she is saying that she will give it to me because she says I need it, but I cannot get—the next day in the mail, it comes to me every month like my son's. His medical card comes every 31st of the month, and I have to call her up and explain why——

Mrs. BOXER. You cannot get a permanent card is what you are saying.

Ms. TORRES. I cannot.

Mrs. BOXER. It is a temporary card, and you keep having to reapply to get this care, is that what you are saying?

Ms. TORRES. Yes. I have to call her and tell her that I need the card for December and she says do you want to pick it up or do you want——

Mrs. BOXER. How long does this take out of your life to do this? It must take a day a month, at least.

Ms. TORRES. Yes. Every time I need one, I have to call her up, I can get it.

Ms. WATERS. Something is wrong. Something is very wrong, and you are being case managed now?

Ms. TORRES. Yes, but—yes, at the Children's Hospital, the case manager.

Ms. WATERS. Yes.

Ms. TORRES. All she could do is call my social worker at the county district office and tell her that I need—it just like if I called her up myself, but I have to pick up the card there with my telephone ID at the cashier's window.

Ms. WATERS. Well, aside from just the bumbling of providing these health services, it appears to me that one of the problems you have described to us is one that is possibly contagious, and it seems to me there would be no question. There is no question that you should receive very supervised care without having to worry about it and I would like to check into it to find out what is going on if you will give me some information.

Mrs. BOXER. Yes. Where is your residence?

Ms. TORRES. I live in Los Angeles.

Mrs. BOXER. About where in Los Angeles because we have to figure out who your Assembly member is and who your Congress Member is. Where—what street or what town?

Ms. TORRES. I live in Hoover and 23d Street.

Mrs. BOXER. Twenty-third and Hoover Streets uses the Southern District. That is Hawkins' congressional district. The first congressional case right here, Ms. Waters has come to you.

Ms. WATERS. I wonder how many more people are out there.

Ms. BEAGLEHOLE. Can I? My name is Ruth Beaglehole, and I run the Teen Parenting and Child Care Program. We are the only program Los Angeles provides for young women coming back to school, through the school. They have dropped out of school. They do not want to return to a high school. So, we provide child care for them on an occupational campus so they can get their high school diploma.

This is one story out of 25, you know, and when I was thinking of who to bring today, I mean, there was any one of 25 young women, and it is—basically, the issue to me is that—the services are a total mystery, you know. It is totally a mysterious process, how anybody gets—how people get care. These teens are always trying to call their social workers just to find out what can I do about this. It is unbelievable the amount of—and I have such respect that they do not give up. I mean I feel that half my job as a support person in these teens' lives is to tell them that we are going to figure this system out. It has got to be figured out. This is a system that needs to work for you, but, you know, I can assure you that it is not working just by watching these young people's lives and they are managing their children.

Mrs. BOXER. And you know what is amazing to me and my colleagues and I, for the 5 seconds she has been in the House, the very Members of Congress who say we must have these babies, a woman should not have the right to choose, must have this baby, must have this child, they are the ones who are no where to be seen when it comes to national health insurance programs, when it comes to well-baby programs.

Ms. BEAGLEHOLE. Exactly.

Mrs. BOXER. And it is a complete outrage, and these are the people who ought to be leading the charge, and I just want to say to both of you, thank you for coming. It has been important for us to hear this story because one of the purposes of this hearing, Congresswoman, is that I am getting solutions, ideas, and I am getting the problems, and your story is just unbelievable.

We just want to commend you for your patience with the system, with your attitude, which I find fantastic. You are just going to go make it happen for yourself and your child, and, you know, if we have anything to say about the things that have been changed, it is hard, you know. President Bush can find all the money he needs for Operation Desert Shield. They said it was going to be $15 billion, now it is $30 billion. He is using up every single penny that he saves in the budget negotiations. Maybe you do not follow what I am saying, but what I want you to know is this President finds the money to build the bombs and does not find the money to take care of babies for all his talk about kinder and gentler.

So, that is what we are going to do when we take this back, is to try and change the priorities of this country, and I want you to know that you have really helped by telling us your story in a very honest, open way, and thank you very, very much.

Ms. TORRES. Thank you.

Mrs. BOXER. Congresswoman, do you have anything to add?

Ms. WATERS. I just want to tell you that you are extraordinary.

Mrs. BOXER. True.

Ms. WATERS. A 2-year-old living on your own, going to school, you are extraordinary, and you are going to do well. You are going to be all right with our help, and I would like to get the information about your MediCal card. We are going to get you a permanent MediCal card.

Mrs. BOXER. And that will be one less burden on all the burdens that you carry out, and I think when the Congresswoman-elect gets on the phone and says here is somebody who is walking around with this contagious disease, you fix it today, I predict it will be fixed within very short order.

I just want to thank all of you for coming to this hearing. It is the last in a series that I have as Chair of this Task Force. I am finished with this Task Force, I am sorry to say, but I will be in other committees that have jurisdiction over health care. So I will continue in this mode and, to me, when I see a child that is suffering because of neglect, the Federal Government's priorities, it just renews my commitment to get back there and fight, and the statistics that I got from all of you today, the stories that I got, some potential solutions that I got, are really going to be very, very helpful.

So, I want to thank you all very, very much, and the Task Force stands adjourned.

[Additional material submitted for the record follows.]

[Tables and charts submitted by Mr. Gates follows:]

TABLE 1
LIVE BIRTHS AND PERCENT WITH LATE PRENATAL CARE OR NO CARE
BY MOTHER'S RACE/ETHNICITY
CALIFORNIA, 1982-1988

(By place of mother's residence)

Year	WHITE(1)			BLACK			OTHER(2)			HISPANIC ORIGIN(3)		
	Live Births	Percent		Live Births	Percent		Live Births	Percent		Live Births	Percent	
		Late Care(4)	No Care		Late Care(4)	No Care		Late Care(4)	No Care		Late Care(4)	No Care
1988	247,803	14.9	1.0	45,222	27.6	3.0	56,773	19.6	1.4	182,910	32.0	3.4
1987	242,018	14.9	0.9	43,149	27.8	2.8	52,158	20.1	1.5	166,051	31.1	3.0
1986	235,848	15.4	0.8	41,327	28.5	2.6	48,308	20.3	1.5	156,422	32.1	3.0
1985	234,493	15.9	0.7	39,829	28.9	1.8	47,303	21.3	1.6	149,191	31.1	2.5
1984	226,965	15.2	0.5	38,285	26.7	1.3	45,209	20.8	0.7	136,935	30.1	2.0
1983	223,967	15.4	0.4	36,416	25.8	1.1	43,838	21.2	0.7	131,501	30.5	2.0
1982	220,675	15.3	0.4	35,604	24.7	0.9	41,297	20.9	0.7	132,055	30.9	2.0

(1) Excludes mothers of Hispanic Origin.
(2) Includes Native American, Chinese, Japanese, Other Asian, Filipino, Pacific Islander, Other, & Not Stated.
(3) Includes mothers of any race category who indicated they were of Hispanic origin.
(4) Prenatal care which began after the first trimester of pregnancy.

Source: California Department of Health Services, 1988 Birth Statistical Master File.

TABLE 1

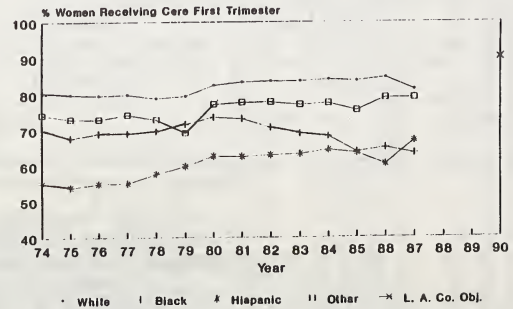
PERCENT DISTRIBUTION OF BIRTHS
BY TRIMESTER PRENATAL CARE BEGAN AND BY RACE/ETHNICITY
LOS ANGELES COUNTY, 1974-1987

YEAR	First Trimester				Second Trimester				Third Trimester				No Prenatal Care			
	White	Black	Hisp.	Other*	White	Black	Hisp.	Other*	White	Black	Hisp.	Other*	White	Black	Hisp.	Other*
1974	80.4	70.0	55.1	74.3	15.0	25.6	29.6	19.0	2.7	4.5	9.4	4.3	1.0	1.0	2.9	0.9
1975	79.8	67.7	54.0	73.1	15.7	25.0	31.2	19.3	2.7	4.0	9.6	4.4	0.6	1.3	2.6	0.8
1976	79.6	69.0	55.0	73.0	16.6	25.0	32.1	20.1	2.7	4.0	8.7	4.5	0.7	1.1	3.3	1.2
1977	79.8	69.0	55.1	74.3	16.3	23.9	32.3	19.3	2.4	3.3	7.7	4.2	0.7	1.0	3.5	1.0
1978	78.8	69.6	57.6	72.9	16.5	23.1	30.3	20.0	2.6	3.7	7.0	4.3	0.6	0.9	2.3	0.6
1979	79.4	71.7	59.8	69.1	14.7	21.5	27.9	15.3	2.2	3.0	6.2	3.6	0.5	0.8	1.9	0.4
1980	82.4	73.6	62.6	77.2	13.7	20.6	28.3	15.9	1.9	3.1	5.4	3.9	0.4	0.7	1.5	0.7
1981	83.3	73.2	62.5	77.7	12.8	20.5	28.7	15.4	1.8	3.1	5.2	3.8	0.4	0.7	1.2	0.4
1982	83.5	70.7	62.9	77.8	12.6	22.1	27.1	14.8	1.9	3.6	5.6	4.0	0.4	0.9	1.9	0.4
1983	83.5	69.0	63.2	77.1	12.3	22.8	26.0	14.8	2.1	4.0	5.7	3.7	0.4	1.0	1.8	0.5
1984	84.0	68.1	64.3	77.5	11.7	24.0	25.5	14.0	2.1	4.5	6.0	3.6	0.5	1.3	2.0	0.7
1985	83.6	63.8	63.4	75.5	11.5	25.9	26.4	14.7	2.0	5.8	5.6	3.9	0.5	1.8	2.0	1.0
1986	84.5	64.9	60.3	78.9	11.3	25.8	29.1	13.0	2.0	4.7	5.8	3.1	0.6	2.8	2.4	0.8
1987	81.2	63.3	66.8	78.9	13.8	27.2	24.1	12.5	2.7	4.7	5.7	2.9	1.0	2.7	1.9	1.0

* Others include: American Indian, Aleutian, Japanese, Chinese, Filipino, Korean, Asian Indian, Vietnamese-Cambodian, Hawaiian, Guamanian, and Samoan. Unknown race/ethnicity and/or unknown prenatal care data excluded.

GRAPH 1

% OF WOMEN RECEIVING PRENATAL CARE DURING THE FIRST TRIMESTER, BY RACE



Los Angeles County, 1974-1987

1988 LOS ANGELES COUNTY BIRTHS
BY HOSPITALS, PRENATAL CARE AND RACE
[redacted]

		TRIMESTER PRENATAL CARE BEGAN					
		FIRST	SECOND	THIRD	NONE	UNREPORTED	TOTAL
HOSPITAL	RACE						
COUNTY	WHITE	613	414	133	114	53	1347
	LATINO	13628	11091	2370	1322	489	28900
	BLACK	1142	881	222	315	53	2613
	OTHERS	389	263	94	42	55	843
	ALL RACES	15772	12649	2839	1793	650	33703
NON-COUNTY	RACE						
	WHITE	40456	4732	789	266	481	46724
	LATINO	39602	13041	2390	424	670	56127
	BLACK	14962	4606	741	336	378	21023
	OTHERS	14935	2053	418	82	228	17716
	ALL RACES	109955	24432	4338	1108	1757	141590
ALL HOSPITALS	RACE						
	WHITE	41069	5146	942	380	534	48071
	LATINO	53230	24132	4760	1746	1159	85027
	BLACK	16104	5487	963	651	431	23636
	OTHERS	15324	2316	512	124	283	18559
	ALL RACES	125727	37081	7177	2901	2407	175293

PREPARED STATEMENT OF SYLVIA DREW IVIE

A. A BRIEF HISTORY OF T.H.E. CLINIC FOR WOMEN

T.H.E. Clinic for Women, Inc. is a private non-profit community clinic which has provided integrated, quality, caring health services to women in Southwest Los Angeles and the surrounding areas since 1974. The eight founding women wanted "...to establish a clinic run for and by women, one that would be a mechanism to effect change away from the exploitation of women, especially in health but also in related fields." Continuing in this tradition, T.H.E. Clinic has gained recognition in the health services community as the only women's clinic that provides services to a culturally diverse clientele and as a long-term advocate for minority women's health care.

The staff and the Board of T.H.E. Clinic reflect the area's ethnic and cultural diversity. The language capabilities include English, Spanish, Japanese, Korean, Vietnamese, Filipino, Thai, Laotian, and Tongan. T.H.E. Clinic employs 40 full-time and part-time staff members and currently has a census of 15,000 medical visits and over 8,000 education/counseling visits per year. The clinic also produces and distributes translated health education materials, and it has distributed over 2,600 pamphlets and other such materials to organizations and agencies nationwide.

The Clinic specializes in gynecological and obstetrical services but has recently expanded to provide screening and referral programs in general health care for women, men, and children. Originally, T.H.E. Clinic served only women and, thus, T.H.E. stood for To Help Everywoman. But as services expanded to include clients' sexual partners and children, T.H.E. became accepted as To Help Everyone.

Major high points in our history include:

1974: T.H.E. Clinic opens for family planning.
1975: T.H.E. Clinic first receives a LARFPC family planning grant, which has been awarded continuously since then.
1980: T.H.E. Clinic receives MCH grant; awarded continuously since.
1988: T.H.E. Clinic received a three-year state AIDS education contract.
1989: T.H.E. Clinic received a federal 330 grant for the Asian Health Venture.
1990: T.H.E. Clinic opens a family practice clinic, two pediatric clinics, and a colposcopy clinic.
1990: T.H.E. Clinic receives a Proposition 99 expanded access grant.
1990: T.H.E. Clinic accepted as a United Way agency.
1990: T.H.E. Clinic receives a grant from the City of Los Angeles towards the purchase of its building.

The Clinic's philosophy is to provide affordable, quality medical and counseling services and to promote responsibility for one's own health care through education and client advocacy. Services are provided on the basis of need rather than ability to pay. Sliding scale fees and copayments based on income are augmented by public and private grants and outside funding. Funding for the Clinic comes from 26 grants, patient fees, corporate and individual donations, and fundraising. (See Exhibit 1 for a list of current funding sources.) The Clinic has consistently overachieved its objectives and has been a long-term recipient of state, federal, county, and city grants based upon contract performance.

The team approach which integrates medical services and other services is an important part of the Clinic's service delivery system. There is a major emphais on community partnerships and health education that promotes responsible decision-making regarding one's health. Services provided by the Clinic have focused on direct medical services, counseling, and education.

In addition to ongoing services, T.H.E. Clinic conducts special clinics free to the community during the year. In May and November, the American Cancer Society co-sponsors a free Pap and Breast Exam Clinic. On each of these days, we provide free cancer screening and breast self-exam instruction to over 100 women. Other special programs have included a Survival Skills Series that we conducted at the Clinic in conjunction with the Rosa Parks Sexual Assault Crisis Center and a Safe Summer Festival held in our parking lot to inform the community of preventive health measures and Clinic services. Children's Day is held in September to help get children ready for school by providing free physicals and other health screenings. The Clinic also conducts special free screening clinics at other community sites, such as the Amalgamated Textile Workers Union and Asian community health centers. The majority of the people participating in these clinics do not have regular medical providers.

B. MEASURES WHICH SUCCEED IN OUR CLINIC

1. Hiring a multilingual, multicultural medical staff. Our physicians, nurses, and medical assistants are African-American, Korean, Latino, and Chinese.

2. Hiring health educators who identify with the populations served economically, educationally, culturally, and linguistically. Our health educators are Latino, African-American, Japanese, Thai, Vietnamese, Tongan, and Filipino.

3. Developing multi-media marketing campaigns responsive to different communities to be served. We concentrate outreach for blacks on radio, outreach for Asian/Pacific Islanders in newspapers, and outreach for Latinas through churches.

4. Providing personal and multi-media educational services within the Clinic going beyond the immediate medical needs. Our topics include smoking cessation, battering, self-esteem, financial management, parenting skills, and risks of lead poisoning.

5. Integrating services in the community so that a family planning patient becomes a prenatal patient, her children become pediatric clients, and her parents become adult medicine patients in the same site.

6. Providing assistance with the Medi-Cal eligibility process. DPPS has provided an eligibility worker in our Clinic, but we supply translation services and work as an advocate for the patient when there are paperwork problems.

C. WHAT IMPEDES OUR PROGRESS IN PROVIDING PRIMARY HEALTH CARE?

1. Transportation - Most of our patients have difficulty getting necessary transportation to the Clinic for care.

2. Cost - Even our low copayments are beyond the financial abilities of many patients to pay. While they are, therefore, often waived, poverty is a continuing barrier to care.

3. Absence Of Prenatal Health Education - The absence of such education in schools and at home means that there is no incentive to get care and to get care early.

4. Segmented Family Planning And Perinatal Services - Many of our prenatal patients get no family planning services or get them elsewhere.

5. Absence Of Funded Teen Support Programs - Teens need help in a myriad of areas in addition to family planning and prenatal services. It is ineffective to supply only medical care.

6. Delays In Medi-Cal Enrollment - Prenatal patients are not certified as quickly as they used to be for care. We need presumptive eligibility.

7. Linguistic And Cultural Barriers - Even with our rich mixture of races and ethnicities, it is not enough in Los Angeles.

8. Absence Of Clinics Targeting Adolescent Males - While our primary service targets are women, virtually all have male partners who are going without real care or health education.

9. Cost of Pharmaceutical Immunizations - The chart (attached as Exhibit 2) shows the cost of immunizastions today (not including staff time or supplies). Providers must front the cost of purchasing such vaccines (sometimes difficult in agencies with very unpredictable government grant cash flows). For patients who are poor but above CHDP eligibility guidelines, the cost is absolutely prohibitive.

10. High Risk Of HIV Infection In Our Patients - T.H.E. Clinic participates with five other primary care clinics in a Centers for Disease Control study of HIV seropositivity. Data on all family planning and pregnancy test patients tested from January 1, 1989 to December 31, 1989 show that African-American women are at higher risk than any other group. Of 1,665 T.H.E. Clinic patients tested, four were HIV-positive, a 0.2% positivity rate. 57.6% of these women were considered to be at "total risk" of HIV infection because they had one or more than one primary at-risk behavior (IV drug use, recipient of blood products 1975-1985, prostitution, sexual contact with a person with any of these risk factors, or sexual contact with a person who is bisexual or has AIDS/ARC or is HIV positive) and who have had more than one sexual partner in the last year or who have had one or more STDs since 1978.

11. Inadequate Referral Mechanism For Hospital Delivery Of Prenatals - T.H.E. Clinic enjoys a unique contractual relationship with UCLA wherein residents provide prenatal care (under the supervision of our Medical Director and the medical staff) and a limited number of patients deliver at UCLA. This results in the highest quality care for our patients. However, we not have a census of 600 or more prenatal patients a year. Over 50 patients per month need a hospital bed for delivery. UCLA gives us 10 beds per month. The other 40 women per month must make arrangements elsewhere. One patient recently delivered in a hospital that was so overcrowded that she was sent home with a fever after her baby's birth but before the placenta had delivered.

12. State Mandate (AB 75) That Child Health Screeners Must Provide All Necessary Treatment After A CHDP Screen - Our Clinic is does not have the staff or the financial resources to provide treatment for all pathologies uncovered during well-child screenings. This is an onerous state requirement.

13. Low Level Of Acceptance In The African-American Community Of Community Clinics As Primary Providers Of Care - Perhaps because there are very few community clinics serving African-Americans or because Medi-Cal (and the attendant private physician access) has been available longer to African-American women than to other minority women, the pattern of black women is not to use public or private non-profit clinics for care. The community belief is often stated that clinic care is inferior to that available from private physicians. This idea can be overcome only by exposure to highly-sensitive, high-quality care in a community clinic context. There is also a fear that the word "clinic" means abortion clinic. There is strong religiously-based resistance to abortion in some segments of the African-American community.

14. Short-Term Funding Problems - Both IRCA-SLIAG and Proposition 99 are targeted to end in the next year. New populations now receiving care will be cut off from a valuable source of funds.

15. Most Of Our Teens Come To The Clinic A Year Or More After They Have Become Sexually Active.

16. While Only 20% Of Our Prenatal Patients Are Teenagers, Many of Our Teens Who Are Pregnant Are Pregnant By Choice Even At Ages As Young As 13 - During 16 years of services, only one child has been put up for adoption by its mother.

17. Absence Of Familial Support - The majority of our prenatal patients are not married and are frequently not with the father of the baby.

D. CONCLUSION

Although we confront numerous structural, financial, political, and cultural barriers to providing care to low-income minority women and children, on balance we are getting the job done and getting it done well. If I could give you an instant remedy, it would be to double our capacity and to duplicate the T.H.E. Clinic model in community-based settings wherever people are experiencing lack of access to quality care across the state and the nation.

1990-1991 INCOME

FEE-FOR-SERVICE:	
L.A.R.F.P.C. - Family Planning	$ 187,276
MCH - Black Infant Mortality	150,000
Medi-Cal	300,000
Immigration Reform Act	195,000
Patient Fees	175,000
Asian Health Venture	143,601
Proposition 99 - Primary Health Care	127,000
State-Funded Asian Hypertension	40,564
HIV Testing	25,000
Hepatitis B	20,000
Primary Health Care Measles	10,000
Syphilis Testing	9,000
Medicare & Private Insurance	1,200
SUB-TOTAL ----------	$1,383,641
GOVERNMENT GRANTS:	
L.A.R.F.P.C. - Asian Information & Education	$ 79,200
City of Los Angeles - Women Are Winners	52,000
State Primary Health Care	20,000
State AIDS Information & Education	60,000
County AIDS Media Campaign	27,576
County Medical Supplies	29,747
City of Los Angeles - Building Grant/Loan (Projected)	150,000
SUB-TOTAL ----------	$ 418,535
PRIVATE DONATIONS/GRANTS/SALES:	
United Way - General Admission (Projected)	$ 20,000
APPCHO - Thalassemia	14,500
APPCHO - AIDS	6,400
Asian Material Sales	2,000
Sub-Lease: Rosa Parks Sexual Assault Center	7,632
Los Angeles Times	5,000
Southern California Gas Company	400
American Cancer Association	750
SUB-TOTAL ----------	$ 56,682
RESERVE	$ 190,000
GRAND TOTAL	$2,048,858

COSTS OF IMMUNIZATION AS OF 8/15/90
Cost Of Pharmaceuticals Only. Does Not Include Supplies.

2 Months		4 Months		6 Months	
Vaccine	Cost	Vaccine	Cost	Vaccine	Cost
DTP	$ 9.49	DTP	$ 9.49	DTP	$ 9.49
OPV	$ 9.20	OPV	$ 9.20	OPV*	$ 9.20
HIB	$13.97	HIB	$13.97	HIB	$13.97
Cost	$32.66		$32.66		$32.66

12 Months		15 Months		4-6 Years	
Vaccine	Cost	Vaccine	Cost	Vaccine	Cost
TB	$ 0.28	DTP	$ 9.49	DTP	$ 9.49
		OPV	$ 9.20	OPV	$ 9.20
		MMR	$24.10		
		HIB	$13.97		
Cost	$ 0.28		$56.76		$18.69

14-16 Years	
Vaccine	Cost
TD	$ 9.49
Cost	$ 9.49

DTP = Diptheria, Tetanus, Pertussis
OPV = Oral Polio Vaccine
HIB = Influenza
MMR = Measles, Mumps, Rubella
TB = Tuberculin
TD = Tetanus, Diptheria

* Optional in high-risk exposure

Exhibit 2

ORAL POLIO VACCINE 2, 4

ORIMUNE (Lederle) 50 doses = $445.70 + $14.50 tax = $460.00.
$460/50 = $9.20 per dose.

DIPTHERIA, TETANUS, PERTUSSIS (DTP) 2, 4, 6, 15

TRI IMMUNOL (Lederle) 7.5 ml./vial x 0.5 cc./vial = 15 doses/vial.
15 doses = $73.96 + $68.40 federal tax = $142.36/15 = $9.49 per dose.

TET DIP AP (Lederle) 5 ml./vial x 0.500/vial = 10 doses/vial.
10 doses = $7.80 + $0.60 federal tax = $8.40/10 = 84 cents per dose.

INFLUENZA B HIB (Lederle) 2, 4, 6, 15

10 doses/vial = $139.70/10 = $13.97 per dose.

MEASLES, MUMPS, RUBELLA 15

MEASLES-ATTENUVAX (MSD) 10 doses/vial.
1 vial = $74.10 + $44.40 federal tax = $118.50/10 = $11.85 per dose.

MMR II 10 doses = 1 vial = $196.70 + $44.40 federal tax = $241.10.
$241.10/10 = $24.10 per dose.

TUBERCULIN PPF (Titus) 12 mos., 4-5, 6-21 mos.

TUBERSOL (Titus) 5 cc./50 test vial = $14.35/50 = 28 cents per dose.

PREPARED STATEMENT OF FERN SEIZER

Venice Family Clinic is a community-based nonprofit State-licensed free clinic providing primary health care without charge to low-income and homeless children and adults.

Since the Clinic began 20 years ago, its mission has been "to provide affordable, accessible and appropriate health care for those who have no other access to such care". The people who are making 38,000 patient visits to our Clinic this year have incomes below the poverty level and no health insurance. In fact, they have no other access to care. They are medically indigent.

Although 92% of our patients have incomes below the federal poverty level, only 6% have health insurance of any kind -- Medi-Cal, Medicare or private. These numbers clearly illustrate the great gap that exists in health care coverage for the poor. The Medicaid program is not reaching the great majority of those who need it. As the State's Little Hoover Commission said last week, Medi-Cal "constitutes an empty promise of health care to many of the 3.7 million who depend on it". In addition to the 127 people a day we see, we are having to turn away many thousands more this year. Who are all these people who need our free clinic's care? 76% are minority group members. 57% speak primary languages other than English. 39% are children and adolescents. 27% are homeless.

Why can't they get health care on their own? More than 9 out of 10 of our patients have family incomes below the poverty level, yet have no health insurance coverage. They are housekeepers, janitors, gardeners, restaurant workers -- they are artists, writers and actors -- they are illiterate and they are out-of-work Ph.D.'s -- they are new immigrants and they are undocumented -- they are former workers in businesses that went under -- they are long-term unemployed and they are "between engagements" -- they are any of us who develop a major illness or a chronic disease for which we have no insurance coverage, who lose or can't find jobs, who can't make the rent payment, who are struggling to care for dependents who themselves have no insurance or support systems. They can't pay for care in the private sector, and the County system in Los Angeles has established barriers that shut them out. There are up-front charges of $35, waits of many months for appointments, day-long waits to be seen for acute care, overcrowded facilities -- and continual and drastic cuts in services. Last week a Superior Court judge ordered that $7.6 million in health care cuts be restored by the County, which had planned to cut an additional $12.7 million in medical services next month. The Judge found that these cuts "unacceptably reduced the accessibility and quality of care," with "irreparable harm to patients".

State law mandates medical services for the poor be comparable to those available to non-indigent people. But, as we have pointed out, that is not happening. The Medi-Calsystem limits patient access in many ways, including an unnecessarily complicated application process (17 pages long)& inadequate reimbursement and long waits for reimbursement that result in fewer and fewer doctors and hospitals accepting Medi-Cal patients. The County, faced with more and more people needing care and shrinking revenues, is cutting access to preventive care, so that people are sicker when they finally get care in an emergency room or are hospitalized.

What we have is a patchwork system of health care for the poor. There are some bright spots in it. The national EPSDT program screening children is one -- in California, it is the CHDP program that has been extended through 18 years and is a model program -- but we also need to be able to treat those problems uncovered in the screening. And California has also taken the big step of including low-income pregnant women as presumptively eligible for Medi-Cal benefits -- but only for health care as related to their pregnancy. Under IRCA (the federal Immigration Act), those eligible for amnesty have health benefits and therefore access as long as the appropriations last. These are the bright spots, and we want to encourage their continuation and replication.

But there are gaping holes. Getting screening exams for children is good -- but we need to be able to provide treatment. And just increasing access for children isn't the answer if their parents can't get care. Access to health care for working age adults -- those between 18 and 65, when Medicare comes in -- is the greatest unmet need.

Those who are not categorically eligible -- for example, not blind or disabled -- are without health care. We know what a difference providing that medical care to very low-income adults has meant. We have kept people working, prevented the spread of communicable disease, kept people with chronic diseases from catastrophic illnesses, treated illnesses in early stages rather than having people show up acutely ill in overcrowded emergency rooms, -- overall, we have helped build a healthier community. But ours is a private, community-based nonprofit response. We are part of the response to a great need -- but that need is far greater than any one part of the system -- or really the un-system -- can meet. The only effective response in the long run is a national health insurance system.

In introducing Concurrent Resolution 375 two months ago, Congressman Henry Waxman called upon Congress to enact a national health program. His program includes the following characteristics: 1) universal access, 2) comprehensive benefits, 3) financing based on ability to pay, 4) cost-containment, 5) a mix of public and private administration, 6) quality and efficiency incentives, 7) fair payment to providers, 8) planning and evaluation, 9) disease prevention and health promotion, and 10) information on quality and cost. We would agree with this approach, adding only a stress on allowing patients as much choice as possible. The health care crisis is growing. We see it in micrcosm at our Clinic. Health care costs and lack of access are escalating, and the number of uninsured and underinsured people is increasing. We need a comprehensive approach that incorporates the best of what we now have and the promise of what could be to make a healthy community for all of us.

PREPARED STATEMENT OF MICHELE MELDEN

The House Budget Committee Task Force on Human Resources has invited the National Health Law Program to provide an overview on the state of health of African American children in Los Angeles and to address, in particular, the cost and accessibiliy of adequate health care.

The National Health Law Program is a health law suppport center that provides legal advice and assistance to Legal Services advocates and their clients. We have ongoing contact with poor people and their representatives throughout the country regarding a variety of health subjects, including Medicaid, which are of vital concern to them. We have extensive experience monitoring children's access to pediatric care and women's access to prenatal care under the Medicaid program.

Over the past decade, Congress has mandated important expansions in Medicaid eligibility and scope of coverage for critical prenatal and children's preventive health services. Unfortunately, due to widespread lack of implementation and outreach, these expansions are not fulfilling the promise of improving the state of poor children's health. This is true not only in the Los Angeles area, but throughout California, and across the nation.

I. INTRODUCTION

African American children nationwide are disproportionately poor and unhealthy. According to recent studies, nearly one-quarter of African American infants had no regular source of

medical care in 1988, compared with 8% of white infants and 12% of children overall.[1] Many such children suffer from physical and mental disabilities that could have been prevented had they had adequate access to health care. These problems are mirrored in California, and in many ways, are magnified and worse in Los Angeles.

Although many poor children and their mothers are eligible to receive medical care under Medicaid (called "Medi-Cal" in California), significant barriers exist which prevent them from receiving the needed medical care to which they are entitled. Among the most significant barriers are low participation in the Medicaid program among physicians, inadequate implementation of expansions in Medicaid eligibility and scope of services by the states, inadequate outreach to eligible women and their children, and states' unlawful delays in processing Medicaid applications. According to a 1987 national study by the General Accounting Office, only 36% of women on Medicaid received adequate prenatal care as compared to 81% of privately insured women.[2]

Inadequate access to prenatal care, and to children's preventive care, brings serious health consequences to many children. The result is tremendous human and social costs

---

[1] These statistics appear in two studies, one by the Department of Health and Human Services, and the other by the National Center for Health Statistics, as cited in Medicine & Health (Nov. 12, 1990).

[2] General Accounting Office, "Prenatal Care: Medicaid Recipients and Uninsured Women Obtain Insufficient Care" 18 (Sept. 1987) (GAO/HRD-87-137).

involved in treating children's physical and mental disabilities. In fact, investments in adequate prenatal care and preventive care for children has proved to be cost-effective: According to Children Now, which has studied access to prenatal care in California, $1 invested in prenatal care saves more than $3 in children's medical care later.[3] While prenatal care and delivery under Medi-Cal cost approximately $1,200, the average Medi-Cal reimbursement for a baby in an intensive care unit (ICU) is $19,000.[4] Similarly, for each dollar invested in immunizations, $10 in medical expenses is saved later.[5]

This testimony describes the consequences of inadequate access to prenatal and preventive care for poor children, and particularly, for poor African American children living in Los Angeles, shows how California is failing to implement its Medi-Cal program to provide these much needed services, and sets forth a list of recommendations on how California can improve its program.

---

[3] Steyer & Lazarus, "Dear Governor X: Please Help Chidren Who Are Trapped in a State of Neglect," Los Angeles Times, M5, Col. 2 (Oct. 28, 1990). See also General Accounting Office, "Prenatal Care: Medicaid Recipients and Uninsured Women Obtain Insufficient Care" supra note 2, at 2, reporting that more than $2.5 billion is spent annually on neonatal intensive care services, primarily for low birthweight infants.

[4] Lazarus & Tirengel, Back to Basics 1988: Strategies for Investing in the health of California's Next Generation 10 (Southern California Child Health Network) (1988).

[5] Steyer and Lazarus, supra note 3.

II. LACK OF ACCESS

A. Prenatal care

Poor women in California suffer grossly inadequate access to prenatal care. One in four pregnant women in California receives no prenatal care or receives it too late to be beneficial.[6] In poor neighborhoods in Los Angeles, fewer than 60% of the women started prenatal care in the first trimester.[7] African American women in Los Angeles are disproportionately affected: they are twice as likely as white women to have no health insurance.[8]

Even women covered by Medi-Cal do not receive adequate prenatal care. In 1988, 30% of Medi-Cal eligible women in California were not able to obtain prenatal care because of the small number of providers willing to accept Medi-Cal payment as payment in full.[9] In 1987, many Medi-Cal eligible pregnant women waited as long as 16 weeks in Los Angeles County to get prenatal care.[10]

Children whose mothers do not receive prenatal care are four

---

[6] Steyer & Lazarus, supra note 3, at 1.

[7] Id.

[8] Brown & Dallek, Changing Health Care in Los Angeles: Poverty Amid Affluence, Competition Leading to Crisis 106 (1989).

[9] Lazarus & Tirengel, supra note 4, at 7.

[10] Id. at 8. However, according to a 1989 report, Los Angeles County claimed to have brought down the waiting time to two weeks. Brown & Dallek, supra note 8, at 56. However, in their effort to do this, less time was spent on prenatal visits, the total number of prenatal visits women was reduced, and resources were shifted so that the waiting time for other primary care increased by 40%. Id.

times as likely to die in the first year of life.[11] Children without prenatal care are three times as likely to be born at a dangerously low birthweight.[12] Children born with low birthweight are at significantly worsened risk of suffering life-long physical and mental disabilities.

Statistics indicate that African American children in California suffer disproportionately by the lack of adequate access to prenatal care: The infant mortality rate among African Americans in California is 15.8/1000, two times that of white infants.[13] Twelve percent of African American babies in California are born with low birthweight, twice the rate of white babies.[14] The result of inadequate access to prenatal care in Los Angeles is that from 1987-88, the infant mortality rate rose 17%, from 8.2/1000 to 9.6/1000.[15] Among African Americans, the increase was 28%; among Latinos, the increase was 30%.[16]

The repercussions of inadequate access are costly. Last year, 1 in 16 California babies was born too early or too small;

---

[11] Lazarus & Tirengel, supra note 4, at 1.

[12] Id.

[13] Id.

[14] American Academy of Pediatrics, "Access to Care" 1 (May 1990).

[15] Castellanos, Echavarria, Forsyth, Galindo, Org, Richardson, BEnsinger, Schimek, Van Houten, The Widening Divid: Income Inequality and Poverty in Los Angeles, Los Angeles: The Research Group on the Los Angeles Economy (UCLA) (1989).

[16] Id.

one-third would have been born on time and healthy if mothers had adequate prenatal care.[17] The number of ICU beds needed by newborns in California increased by 60% between 1980-86, while the number of total births increased only by 20%.[18] According to a 1988 study, California would have saved at least $30 million annually if it had provided adequate prenatal care.[19]

In addition to providing adequate prenatal care, providing pregnant women with adequate access to drug rehabilitation services is essential to safeguard the health of newborn infants. However, drug treatment is largely unavailable to pregnant women.[20] Two-thirds of hospitals surveyed by the House Select Committee on Children, Youth and Families reported that they had no drug treatment programs to which pregnant women could be referred; none reported the availability of special programs providing both comprehensive treatment and prenatal care.[21]

The most recent estimate is that 11% of all babies born nationwide evidence some extent of prenatal drug exposure.[22]

---

[17] Id.

[18] Lazarus & Tirengel, supra note 3, at 9.

[19] Id. at 13.

[20] Fink, "Effects of Crack and Cocaine on Infants: A Brief Review of the Literature," 24 Cl. Rev. 460, 463 (Special Issue 1990).

[21] Id., citing Select Commitee on Children, Youth and Families, "Principal Findings on Addicted Infants and Their Mothers" (1989).

[22] Chasnoff, Landress & Barrett, 322 New Eng. J. Med. 1202-06 (1990).

Based on that figure, more than 5,000 drug-exposed infants were born in Los Angeles County in 1989. An estimated 3 babies per 1,000 live births suffer from fetal alcohol or drug syndrome.[23]

The effects are costly. An estimated 70,000 children nationwide were born with fetal alcohol or drug syndrome and cost $670 million per year to treat for a wide array of problems.[24] If an addicted woman's child is taken from her by the state, the cost of a three- to four-year placement is about $19,000 per child.[25]

Medicaid historically provided only limited drug rehabilitation coverage through in-patient psychiatric care and did not cover treatment at residential centers. However, recent expansions in the Omnibus Budget Reconciliation Act (OBRA) of 1990 now give states the option of using Medicaid to provide pregnant women drug rehabilitation services in residential treatment centers. Studies have shown that comprehensive drug treatment in such programs significantly improves the birth outcomes and mortality rates for drug-exposed infants.[26]

---

[23] Gates & Beck, "Prevention and Treatment: The Positive Approach to Alcoholism and Drug Dependency," 24 Cl. Rev. 472, 474 (Special Issue 1990).

[24] Id.

[25] Id.

[26] See Fink, supra note 20.

B. Delivery care

Poor women's problems obtaining access to needed care during their pregnancies continue when they are ready to deliver. The county hospitals that disproportionately serve poor women in Los Angeles are operating dangerously beyond their capacities. This is in large part caused by the low number of private hospitals willing to accept Medi-Cal eligible women.

Since 1983, California has contracted with specific hospitals at which Medi-Cal beneficiaries who live in certain geographic areas must receive all but emergency services. California receives a special waiver to operate this "Selective Provider Contracting Program." The purpose of the program is to control rates while purportedly ensuring adequate access. Unfortunately, the program is creating a crisis because facilities that have been awarded Medi-Cal contracts do not have sufficient capacity to treat the large number of low-income women requiring their services.

A recent study found that Los Angeles' county hospitals, which receive Medi-Cal contracts under this waiver, and the hospitals to which the county hospitals send their patients when they are overcrowded, are operating well beyond their capacity for delivering newborns.[27] Harbor-UCLA Medical Center in Torrance, a major contracting hospital in South Los Angeles, has

---

[27] Richwald, Morrison, DeVane, "Obstetrical Delivery Service Capacity in Los Angeles County: An Analysis of the Current Crisis" 4, (Report Funded by the Los Angeles County Dept. of Health Services) (Sept. 1990)

reported that it is operating at 130% of its delivery capacity.[28] It became so overcrowded one day last August that one staff obstetrician stopped admitting patients, including women in labor, and instead, handed them road maps to other facilities.[29] Overcrowding puts many of these mothers and children at serious risk.

California's Selective Provider Contracting Program is up for renewal of its federal waiver in November 1990. Unless California demonstrates that it is providing adequate access through this system, which clearly is not the case, the extension should not be granted.

C. Preventive care for children

African American children nationally suffer disproportionately from preventable childhood diseases, lead poisoning, sexually transmitted diseases, and AIDS. The health of African American children in California and Los Angeles reflects these national trends.

For example, more than one-half of California's children are not fully immunized.[30] Fifty percent of all 2-year-olds in California have not been immunized for DPT; among African-

---

[28] Wielawski, "County Offers Plan to Ease Obstetrical System Chaos," Los Angeles Times, A1 (Sept. 26, 1990).

[29] Id.

[30] Steyer & Lazarus, supra note 3.

American and Latino children, the figure is 75%.[31] A 1985 study showed that compliance with immunization school entry requirements in Los Angeles County, where the greatest proportion of African Americans in California resides, is only 76%, lower than in California as a whole.[32]

In the first nine months of 1990, there were 9,000 cases of measles in California, more cases than in the last nine years combined. So far, 46 people have died, the majority of them children under four years old.[33] The largest outbreak of measles in the current national epidemic has occurred in Los Angeles County.

Lead poisoning is also a serious problem for children today. The prevalence of lead in our everyday environment has resulted in an epidemic affecting an estimated three to four million children nationwide.[34] When left untreated, lead poisoning can cause permanent neurological damage and impair educational performance. Children under age six are the most vulnerable to its effects. The problem of lead poisoning disproportionately affects poor and minority children living in urban areas.

---

[31] American Academy of Pediatrics, "Access to Care," supra note 14.

[32] Abel & Brown, The Child Health and Disability Prevention Program in California (produced by the National Health Law Program and the National Center for Youth Law) (1985).

[33] Conversation with Bonnie Glazer, Children's Research Institute, Nov. 7, 1990.

[34] Environmental Defense Fund, "Legacy of Lead: America's Continuing Epidemic of Childhood Lead Poisoning," (March 1990).

According to a recent study, over 67% of African American inner-city children and nearly 17% of all urban children in the United States are suffering from excessive lead exposure.[35]

There is also an increased incidence of AIDS among children in California. The pediatric AIDS-related death rate has increased 70% in the last year. Almost one-half of pediatric AIDS cases in California are in Los Angeles. Twenty-eight percent of children in California diagnosed with AIDS are African-American.[36]

II. MEDICAID EXPANSIONS: THE PROMISE AND THE REALITY

A. Prenatal care

Access to prenatal care is critical to reducing infant mortality and low birthweight rates.

Since 1986, Congress has made important expansions in providing poor women prenatal care under Medicaid. It has done so by raising income eligibility criteria for pregnant women, and by covering pregnant women regardless of their family composition. Congress' express intent has been to bring down unconscionably high infant mortality rates.

---

[35] Mushak & Crocetti, "Determination of numbers of lead-exposed American children as a function of lead source: integrated summary of a Report to the U.S. Congress on Childhood Lead Poisoning," 44 Environ. Research 210-29 (1989).

[36] Conversation with Dr. Mary Jess Wilson, California Dept. of Health Services, November 6, 1990.

In line with these expansions, California raised the income eligibility ceiling for pregnant women to 200% of the federal poverty level and removed all citizenship requirements for women seeking Medi-Cal for pregnancy-related services. In addition, California provides a specially funded service called the "Comprehensive Perinatal Care Program" which provides pregnant women with nutritional assistance and counseling in addition to medical care.

The key to whether eligible women actually receive necessary prenatal care is participation by providers. In 1988, California significantly improved its obstetric rates and improved its procedures for processing reimbursement claims submitted by providers. Unfortunately, California still has not reached out to inform providers of improved Medi-Cal reimbursement or of changes enacted to expedite claims processing. The result is that even though California's obstetric reimbursement rates are high compared to most other states, participation still is very low, as reflected in the lack of access experienced by Medi-Cal eligible women.

Moreover, although Medi-Cal's obstetric rates are relatively high, its rates for necessary anesthesiology and radiology services accompanying a delivery are not comparable. In fact, anecdotal reports suggest that even where obstetricians would like to accept Medi-Cal eligible women, anesthesiologists and radiologists are pressuring hospitals to limit the number of Medi-Cal deliveries.

OBRA of 1989 codified a regulatory requirement that provider reimbursement rates be "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[37] California is not implementing this requirement in setting anesthesiology and radiology rates.

In addition, OBRA of 1989 requires that states submit reports to the federal government showing how their obstetric and pediatric reimbursement rates will satisfy the above requirement of equal availability.[38] California is one of of only two states in the country that has failed to submit a report. It is essential that California submit a report assuring that its obstetric rates conform to federal law.

In addition to low provider participation, delays in application processing are posing a significant barrier. Advocates for low-income adults and children have filed a suit recently, Garcia v. Bd. of Supervisors of Los Angeles,[39] challenging California's failure to process Medi-Cal non-disability applications within the 45 days required by federal law. According to the above complaint, at the end of March 1990, Los Angeles had more than 10,000 Medi-Cal applications pending

---

[37] 42 U.S.C. § 1396a(a)(30)(A).

[38] 42 U.S.C. § 1396r-7.

[39] No. CV 90-4095 (C.D.Cal., filed Aug. 9, 1990).

more than 60 days. As a result of such delays, pregnant women have gone without prenatal care until it is too late to make a difference.

Partially in order to expedite eligibility determinations, Congress gave states the option of waiving resource tests for pregnant women.[40] Unfortunately, California has not exercised this option. The current application for Medi-Cal is 12 pages long. It could be reduced greatly for pregnant women if California eliminated a resource test.

Congress also gave states the option of making available "presumptive eligibility" so that women can begin eligibility while their application is being processed, as long as they obtain a medical verification of their pregnancy by a physician.[41] California has adopted a watered-down alternative which allows the county welfare departments to make "conditional eligibility" determinations instead of providers. This program is substantially weaker because women still must apply to the welfare offices to obtain initial coverage, defeating the purpose of relying on a medical verification to begin coverage immediately rather than withholding coverage until a woman makes a separate application at the welfare office. Furthermore, "conditional eligibility" is failing in the way it has been

---

[40] 42 U.S.C. § 1396a(l)(3)(A).

[41] In the recently-passed OBRA of 1990, Congress stressed the importance ofthis provision by lengthening the presumptive eligibility period.

implemented because many of the local welfare workers are not following the new rules requiring them to grant immediate eligibility.

Also contributing to delays in obtaining prompt eligibility determinations are tremendous overcrowding at registration sites, due to a shortage of eligibility workers, and the lack of adequate translation services. California has made some improvements by "outstationing" eligibility workers in community clinics to take applications there. Such efforts are very helpful and should be expanded.[42]

In addition, Medicaid requires that states assure availability of transportation to necessary medical care.[43] Medi-Cal provides some assistance in Los Angeles, but it has been far from adequate to meet eligible women's needs.

B. EPSDT

States participating in Medicaid must provides "early and periodic screening, diagnostic, and treatment" (EPSDT) services for all Medicaid eligible children under age 21. EPSDT is the key preventive health program available to poor children. It

---

[42] OBRA of 1990 now mandates such "outstationing" to begin July 1, 1991. All states will be required to accept and initially process Medicaid applications from pregnant women and children at disproportionate share hospitals, federally qualified health centers, and other outreach sites selected by the states. In addition, the application form must not be the full length of the regular application that combines AFDC, Food Stamps, and Medicaid, but must be a form used only for Medicaid.

[43] 42 C.F.R. § 431.53.

offers a tremendous promise of preventive care and treatment to children. It should be used to identify health problems before they become serious and to link children to corrective treatment. California's version is called the Child Health and Disability Prevention (CHDP) Program.

Under OBRA of 1989, Congress enacted significant improvements in the EPSDT program.[44] Federal law now requires that health screens under CHDP consist of a comprehensive health and developmental history, including: a) a comprehensive unclothed physical examination; b) a nutritional assessment; c) appropriate immunizations; d) appropriate laboratory tests (including lead toxicity screenings); and e) anticipatory guidance (including screens for drug dependence and sexually transmitted diseases). States also are required to provide children with separate vision, hearing, and dental screens and services, including preventive dental care. The screens must be provided in accordance with guidelines established by the American Academy of Pediatrics, and must be provided at periodic and, if medically appropriate, "interperiodic" intervals. States may not require that children obtain prior state authorization before receiving their screens. Finally, children are entitled to receive follow-up care for any conditions discovered in the

---

[44] OBRA of 1990 also expanded eligibility for low-income children, requiring that all states increase income eligibility limits for children ages 6 and 7 to 100% of poverty, effective July 1, 1991. In addition, OBRA of 1990 phased in coverage for older children one year at a time so that all children up to 18 will be covered to 100% of poverty by 2003.

screen, whether or not the state Medicaid plan otherwise covers such care.

Unfortunately, California has failed to implement the 1989 expansions. California currently does not provide for lead assessments or interperiodic screens, is imposing prior authorization limits on screens, and still is limiting follow-up services to those already provided in its Medicaid plan, in direct conflict with federal law.

Even under California's flawed CHDP program, very few eligible children are receiving any benefits. A 1985 study found that CHDP screened only 46% of eligible children under 5 years of age; 9% of eligible children over 6; and overall, less than 25% of eligible children.[45] Another 1985 study confirmed that only a tiny proportion of eligible children received the screens; a high percentage of the health assessments were incomplete; and the program failed on the whole to link children to follow-up diagnosis and treatment.[46] According to this study, Los Angeles County had the lowest screening ratio; it only provided 25% of the required screenings.

Even if children are screened, they rarely can obtain the necessary follow-up care. A 1985 study found that the majority of private physicians who serve as CHDP screeners rarely provide

---

[45] American Academy of Pediatric, "Access to Care," supra note 14.

[46] Abel & Brown, supra note 32.

ongoing care.[47] Furthermore, this same study found that the majority of health centers provide only screenings and have no continuing care arrangements with the State.[48]

Low pediatrician participation is due in large part to the small number of pediatricians willing to accept Medi-Cal as payment in full. The primary reason given by pediatricians is the low reimbursement rates. According to an American Academy of Pediatrics (AAP) national study, the average Medicaid payment for pediatricians is 54% of the private fee; at the same time, pediatricians reported on average that 54% of their fee goes to overhead.[49] According to an AAP study on rates in California, the situation is worse: Medi-Cal pays 40% of the usual and customary charge, while the average pediatrician's overhead is 50-55% of that charge.[50]

Dental participation is even lower. According to data provided by California's Department of Health Services, no dentists are accepting Medi-Cal in 12 counties; and no specialists are participating in 27 counties.[51] Denti-Cal pays 35-40% of dentists' usual rates, which in many cases is not high

---

[47] Id.

[48] Id.

[49] Yudkowsky, Cartland & Flint, "Pediatrician Participation in Medicaid: 1978-1989," 85 Pediatrics 567-77 (April 1990).

[50] American Academy of Pediatrics, "Access to Care," supra note 14.

[51] See Clark v. Kizer, No. Civ. S-87-1800 LKK (E.D.Cal. Oct. 3, 1990).

enough to cover overhead.[52]

California also is failing to cover adequately dental services for children. A recent Office of Technology Assessment study of 7 states, including California, found the EPSDT program in each state failed to cover adequately "basic" dental services.[53]

As with prenatal care, California's failure to process Medicaid applications promptly is preventing children from receiving needed services; in fact, because of delays, newborns have failed to receive initial medical check-ups at birth, and children have been denied access to EPSDT preventive services.[54]

Children also suffer from discontinuous eligibility. A large number of children go on and off Medicaid, which thwarts the preventive benefits of the EPSDT program. California has attempted to ameliorate such problems by providing EPSDT to children up to 200% of poverty, and to babies who lose Medicaid eligibility until they are 13 months old. However, some experts have recommended that continuing coverage until age 6 can make a life-long difference in preventing serious physical and mental disabilities.[55]

---

[52] Id.

[53] Office of Technology Assessment, Children's Dental Services Under the Medicaid Program (Sept. 1990).

[54] See Garcia v. Bd. of Supervisors, No. CV 90-4095 (C.D.Cal., filed Aug. 9, 1990).

[55] See Abel & Brown, supra note 32.

A further problem is lack of transportation. OBRA of 1989 expanded on states' existing obligations to assure that Medicaid beneficiaries have access to transportation by providing that in the EPSDT program, states must provide "support services." The Health Care Financing Administration (HCFA) has interpreted "support services" to mean that states have an affirmative obligation to offer both transportation and scheduling assistance prior to each due date of a child's periodic examination under EPSDT.[56] California has failed to implement these improvements.

IV. HOW TO IMPROVE ACCESS

A. Prenatal and delivery care

California would greatly improve access to adequate prenatal care if it adopted the following changes:

1. Improve provider participation. This includes setting adequate rates for obstetricians as well as anesthesiologists and radiologists, and informing and educating providers about the improvements so as to encourage them to participate. In addition, California must submit a report documenting how its rates satisfy the statutory equal availability requirement.

2. Enlarge hospital participation. The Los Angeles County hospital system is in a state of crisis that puts both the mothers' and newborns' lives at risk. The "Selective Provider

---

[56] HCFA, State Medicaid Manual, § 5150 (Transmittal No. 3) (April 1990).

Contracting Program" clearly is not working to assure adequate access. California's November request for an extension on its waiver to continue this program should be rejected.

3. Provide case management to at-risk mothers. Individualized nutrition, psychosocial, health education, and case coordination services are necessary to reduce infant mortality and low birthweight rates. California's Comprehensive Perinatal Care Program is an excellent service and should be expanded.

4. Provide drug rehabilitation services in residential centers. Studies have shown that drug rehabilitation services in such centers combined with prenatal care make a critical difference in protecting newborns against lifelong disabilities caused by drug exposure.

5. Improve the process for determining Medi-Cal eligibility.

a. California should waive the resource test for pregnant women.

b. California should adopt presumptive eligibility as set forth in the Medicaid Act.

c. California should abide by federal law and process applications within 45 days.

d. California should improve the application process by stationing more eligibility workers at clinics where women receive prenatal care, and by providing adequate translation services. OBRA of 1990 mandates such "outstationing"

at disproportionate share hospitals and federally qualified health centers as of July 1, 1991. California should implement these new requirements.

6. Improve access to transportation services.

B. EPSDT

California would greatly improve access to children's preventive services if it took the following steps:

1. Modify its state plan to conform to federal law. Particular areas of importance are: a) covering all services necessary to correct or treat conditions detected in a screen; b) requiring lead blood assessments; c) requiring interperiodic screens; and d) removing prior authorization requirements for screens.

2. Effectively implement key EPSDT requirements. Special emphasis should be placed on: a) enlisting adequate numbers of screeners and continuing care providers; b) providing outreach and education to providers on the rates and scope of coverage available under CHDP; c) educating and reaching out to families with Medi-Cal eligible children to inform them of the availability and benefits of CHDP; d) improving immunization rates; e) providing adequate dental care; and f) targeting adolescents to meet their special needs in areas of nutrition, drug dependence, sexually transmitted diseases, family planning, and prenatal care.

3. Improve provider participation among both

pediatricians and dentists. California must make necessary reimbursement rate adjustments to satisfy the equal availability requirement, and submit a state report to HCFA on pediatric rates that demonstrates adequately how the equal availability requirement is being met.

4. Improve the application process. California must conform to federal law on timely determinations. In addition, California should ensure that all children are Medi-Cal eligible at the time of the screen so they will be eligible for follow-up care.

5. Improve access to transportation. California should conform to improvements in federal EPSDT law requiring states to provide transportation and scheduling assistance for eligible children.

7. Look to model programs for improvement:

a. South Carolina: South Carolina presently has the highest EPSDT screening ratio in the country: 83 exams per 100 eligible children. The state undertakes extensive outreach. It has developed a newborn home visiting program, under which a registered nurse makes a home visit to every Medicaid-covered newborn within 60 days of birth. The nurse explains the benefits of preventive health care and encourages the family to enroll and participate in EPSDT. The nurse also provides a nutritional assessment, examines the child's gross health appearance, assesses the home environment and patterns of health care use, and provides referrals to a primary care provider. The state

also has devised an outreach program for children in specific age groups considered to be in greatest need of home visits, and has given special attention to dental care, targeting newly enrolled and re-enrolled children ages 3 to 13.[57]

b. New Jersey: New Jersey has instituted an exemplary program providing adolescents EPSDT services alongside other social services. The "School Based Youth Services Program" (SBYSP), developed by the New Jersey Department of Human Services, serves adolescents between ages 13-19 who are at risk of dropping out of school, becoming pregnant, using drugs, developing mental illness, or becoming unemployed. Each SBYSP site offers a comprehensive range of services, including: employment counseling; job training and placement; summer and part-time job development; drug and alcohol abuse counseling; family crisis counseling; academic counseling; primary and preventive health services; recreation; and referrals to health and social services.

c. Minnesota: Minnesota offers a comprehensive preventive health program to all uninsured children up to age 8. This is particularly important to achieve the preventive goals available under EPSDT and to offset the problem of discontinuous enrollment.

---

[57] For a more detailed analysis of this program, see Children's Defense Fund Southern Regional MCH Project, "Increasing the Proportion of Children Receiving EPSDT Benefits: A South Carolina Case Study" (July 1990) (Prepared by Joseph Tiang-Yau Liu).

V. CONCLUSION

Poor children throughout California, and significantly, within Los Angeles County, are suffering the consequences of inadequate access to preventive health care and of their mothers' inadequate access to prenatal care. The result is tragic and costly lifelong physical and mental disabilities affecting a disproportionate number of African American children. If California were implementing its Medi-Cal program properly, and opting to make significant improvements, much of this harm could be avoided.

[Whereupon, at 11:30 a.m., the Task Force was adjourned.]

35-971 (88)

CMS LIBRARY
3 8095 00012585 2